

1 STATE OF OHIO)
)
2 COUNTY OF LORAIN)
) SS:

3 IN THE COURT OF COMMON PLEAS

4 NANCY DUNHAM, et al.,
5 Plaintiffs,

6 vs.

NO. 97CV119540

7 MANHAL A. GHANMA, M.D.,
8 Defendant.

COPY

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10

11 DEPOSITION OF: Richard J. Friedman, M.D.

12 DATE: July 13, 1999

13 TIME: 1:00 PM

14 LOCATION: Hood Law Firm
15 172 Meeting Street
 Charleston, SC

16 TAKEN BY: Counsel for the Plaintiff

17 REPORTED BY: Janice N. Shepherd,
18 Registered Professional
 Reporter

19

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25

RICHARD J. FRIEDMAN, M.D. - EX. BY MR. MISHKIND

1 RICHARD J. FRIEDMAN, M.D.

2 being first duly sworn, testified as follows:

3 EXAMINATION

4 BY MR. MISHKIND:

5 Q. Let the record reflect that we are here
6 in Charleston, South Carolina, on July 13, 1999, for
7 purposes of conducting the discovery deposition of
8 Dr. Friedman who has been identified as an expert to
9 be called on behalf of Dr. Ghanma in the trial of
10 this case. Would you please start out by stating
11 your full name for the record?

12 A. Richard Joel Friedman.

13 Q. And you are a physician; is that correct?

14 A. Yes.

15 Q. Dr. Friedman, it is my understanding that
16 you have been retained by Mr. Travis on behalf of
17 Dr. Ghanma to testify on his behalf. Is my
18 understanding correct?

19 A. Yes.

20 Q. Now, I have -- and you will be
21 testifying, by the way, at the trial which is
22 scheduled in October up in northeastern Ohio?

23 A. Yes.

24 Q. Have arrangements been made for you to
25 come to Ohio for purposes of your testimony?

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1 A. No.

2 MR. TRAVIS: Howard, we've got to talk
3 about setting aside time for your doctor and my
4 doctor, but we will be making arrangements. I wanted
5 to talk to you to see if we can agree as to a certain
6 date that the doctor will testify.

7 MR. MISHKIND: We can deal with that off
8 the record.

9 BY MR. MISHKIND:

10 Q. However, my question to you is, you are
11 aware of the trial, and your intent is to come to
12 northeastern Ohio to testify in person; is that
13 correct?

14 A. Yes.

15 Q. Now, I have a report that you wrote dated
16 March 17, 1999. Do you have your report there as
17 well?

18 A. Yes.

19 Q. Have you written any other letters or
20 reports to Mr. Travis in connection with this case?

21 A. No.

22 Q. Have you written any other letters to
23 Mr. Travis at all in connection with this case?

24 A. No.

25 Q. Did you prepare a draft of that letter

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1 before you finalized it.

2 (This page contains information to be
3 supplied by counsel and/or the deponent.)

4 A. No.

5 Q. I also have been provided with a copy of
6 your CV. My copy is 63 pages, is dated October 9,
7 1998. Would there need to be any changes made on
8 that to bring it up to date?

9 A. Yes.

10 Q. Can you tell me what additions or
11 deletions? Do you want to take a look at it?

12 A. Probably just some more articles,
13 publications, talks, maybe a grant or two, just
14 continuing on.

15 Q. Do you -- I'm sorry, I didn't mean to
16 interrupt you.

17 A. No.

18 Q. Do you have a copy of your current CV
19 with you?

20 A. No.

21 Q. Would you provide a copy of that to
22 Mr. Travis so that he can send me a copy of your
23 current one?

24 A. Certainly.

25 Q. Doctor, can you tell me whether there are

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1 any articles or publications in your CV that are
2 relevant to the opinions that you hold in connection
3 with the care provided by Dr. Ghanma of Mrs. Dunham
4 in this case?

5 A. What do you mean by relevant to my
6 opinion?

7 Q. Are there any articles that you have
8 written that deal with the use of hemiarthroplasty in
9 the treatment of three- or four-part proximal humeral
10 fractures?

11 A. Yes.

12 Q. Are there any that deal with the success
13 of hemiarthroplasty and the treatment of three- or
14 four-part fractures?

15 A. I believe that there are some articles
16 that mention that. There is not a specific series
17 examining a specific group of patients and their
18 outcome.

19 Q. The first question you answered
20 affirmatively, that there are articles that deal with
21 the use of hemiarthroplasty in the treatment of
22 proximal humeral fractures, correct?

23 A. Yes.

24 Q. Could you quickly take a look at your CV
25 and perhaps even circle on the CV the numbers?

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1 A. Number 95 and what would be 115. Some of
2 the numbers didn't come out.

3 MR. TRAVIS: Number 95 on which page,
4 Doctor?

5 THE WITNESS: I'm sorry, page 18, and the
6 one with lead author as Hartsock on page 19. Those
7 would be the two.

8 BY MR. MISHKIND:

9 Q. Have you given any presentations or done
10 any research relative to the use of a
11 hemiarthroplasty in the treatment of proximal humeral
12 head fractures?

13 A. To the best of my recollection, no
14 research, but I've probably given some presentations
15 on that topic, yes.

16 Q. Would they also be outlined in your CV as
17 well?

18 A. Yes.

19 Q. Could you, with the same request, take a
20 look at that and let me know which ones?

21 A. Number 141 on page 44, 236 on page 52.
22 That's about it.

23 Q. Are there any articles or presentations
24 that are relevant to any of the issues that you
25 believe to be germane to this case that are either --

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1 that have been submitted --

2 (The proceedings were interrupted.)

3 THE WITNESS: Could we take a break for a
4 second?

5 MR. MISHKIND: Okay.

6 (Off-the-record conference.)

7 (This page contains information to be
8 supplied by counsel and/or the deponent.)

9 BY MR. MISHKIND:

10 Q. Strike that question. I'll start over.
11 Are there any articles that will be covered in your
12 updated CV or any presentations that you believe to
13 be relevant to any of the issues in the Nancy Dunham
14 versus Dr. Ghanma case?

15 A. There might be.

16 Q. When you submit the copy of the CV, would
17 you take a look and circle any additional articles or
18 presentations that you believe to have some relevance
19 to the issues in this case?

20 A. Sure.

21 Q. Do you have copies of the presentations
22 which you circled, which would be presentation number
23 141 and number 236, back at your office?

24 A. No.

25 Q. Where would those materials be?

1 A. They probably don't exist.

2 Q. Was there material disseminated at the
3 time you gave those presentations?

4 A. I have to look and see specifically.
5 There might have been for 236. There was not for
6 141.

7 Q. Your testimony is that for 236, though,
8 that the material that was disseminated would no
9 longer be available?

10 A. Correct.

11 Q. Doctor, are you an American citizen?

12 A. Yes.

13 Q. When did you become an American citizen?

14 A. October '96.

15 Q. Have you ever been sued for medical
16 malpractice?

17 MR. TRAVIS: Objection. You can answer.

18 THE WITNESS: I was named in a suit
19 initially and then dropped a couple of months later.

20 BY MR. MISHKIND:

21 Q. How long ago was that case?

22 MR. TRAVIS: Can I have a continuing
23 objection?

24 MR. MISHKIND: Sure.

25 MR. TRAVIS: Go ahead, Doctor.

1 THE WITNESS: '92, '93, I think.

2 BY MR. MISHKIND:

3 Q. Was that here in South Carolina?

4 A. Yes.

5 Q. What was the name of the plaintiff in
6 that case?

7 A. I believe at the time it was Andrea Ross.

8 Q. Do you recall the subject matter of the
9 procedure?

10 A. She had a hip replacement.

11 Q. You're board certified, correct?

12 A. Yes.

13 Q. Were you successful in becoming board
14 certified the first time around?

15 A. Yes.

16 Q. Both oral and written?

17 A. Yes.

18 Q. Have you ever had your license
19 restricted, revoked, suspended, or otherwise drawn
20 into question?

21 A. No.

22 Q. Ever had your hospital privileges
23 revoked, suspended, or limited in any way?

24 A. No.

25 Q. Have you ever had an application for

1 hospital privileges denied?

2 A. No.

3 Q. What percentage of your professional time
4 is spent in the active clinical practice of medicine?

5 A. 80 percent, 90 percent.

6 Q. What do you do with your other
7 professional time?

8 A. Research, teaching, administrative
9 responsibilities.

10 Q. Can you describe for me your clinical
11 practice? What does it consist of?

12 A. Monday mornings I operate. Monday
13 afternoons I see patients. Tuesday mornings I
14 operate. Tuesday afternoons is open for research,
15 teaching, administrative responsibilities. Wednesday
16 I operate all day. Thursday I see patients all day.
17 Fridays I operate in the mornings, and afternoons are
18 open for catch-up, clean-up, some patients, whatever
19 else.

20 Q. Do you currently do any teaching in any
21 medical schools?

22 A. Yes.

23 Q. Which ones?

24 A. I'm a professor of orthopedic surgery at
25 the Medical University of South Carolina here in

1 Charleston.

2 Q. Any other universities?

3 A. I have an adjunct professorship of
4 bioengineering at Clemson University.

5 Q. Do you have an engineering degree as
6 well?

7 A. No.

8 Q. Can you explain to me how you became an
9 adjunct professor of bioengineering?

10 A. I've done a lot of research in
11 biomechanics, particularly related to the shoulder,
12 and did a lot of that with the folks at Clemson,
13 amongst other work, and I guess that's where it
14 stemmed from.

15 Q. Do you know Dr. Stephen Kay?

16 A. I know who he is. I don't know him
17 personally.

18 Q. Have you ever met him at any conventions
19 or --

20 A. I think I may have met him once or twice.

21 Q. Do you know of Dr. Kay's professional
22 reputation in the area of shoulder or shoulder
23 surgery?

24 A. I know he has a shoulder practice out in
25 Los Angeles.

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1 Q. Do you know anything about his reputation
2 as a shoulder surgeon?

3 A. My understanding is he is a very good
4 doctor.

5 Q. Doctor, would you tell me what journals
6 you refer to when you want reliable studies in the
7 treatment of proximal humeral fractures?

8 A. I don't rely or refer to any specific
9 journals.

10 Q. What journals or studies do you look to
11 for reliable information dealing with the success or
12 complications associated with hemiarthroplasties?

13 MR. TRAVIS: Objection, since you really
14 haven't defined reliable. You can answer, Doctor.

15 THE WITNESS: I don't rely on any
16 specific journals, articles, or books.

17 BY MR. MISHKIND:

18 Q. I'm not suggesting you rely on any
19 specific ones. But if you wanted any information on
20 recent studies concerning complications following
21 hemiarthroplasty, where would Dr. Friedman look first
22 for studies dealing with complications and treatment
23 following hemiarthroplasty?

24 A. Probably the computer, do a literature
25 search and find out what has been published over the

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1 last two, three, five years, whatever period I was
2 looking at, and find out who has published articles
3 on that topic.

4 Q. Have you for purposes of this case done
5 any medical research?

6 A. No.

7 Q. Do you intend to take the stand and
8 indicate that any particular article or any
9 particular study is authoritative in connection with
10 the issue of the treatment of post hemiarthroplasty
11 complications?

12 A. No.

13 Q. Are you familiar with the article that
14 Dr. Kay wrote on hemiarthroplasties?

15 A. Yes.

16 Q. Have you read that article?

17 A. I have read it in the past and reviewed
18 it before with Mr. Travis.

19 Q. And do you consider it to be a
20 well-written article on the topic?

21 MR. TRAVIS: Objection, if you understand
22 what well-written means.

23 THE WITNESS: I think it's a small number
24 of patients, different diagnoses, different
25 prostheses used, and I think it's difficult to draw

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1 any definitive conclusions from that. It's more just
2 a descriptive paper indicating how their 15 patients
3 did.

4 BY MR. MISHKIND:

5 Q. Are you aware of any articles or can you
6 cite me to any articles that talk about the success
7 of a secondary surgery following a failed original
8 hemiarthroplasty for a patient who had a traumatic
9 proximal humeral head fracture?

10 A. Not off the top of my head, no.

11 Q. You haven't written anything that talks
12 about the success of secondary surgeries in that
13 setting, have you?

14 A. No.

15 Q. Have you served as an expert witness
16 before this case?

17 A. Yes.

18 Q. On how many occasions?

19 A. I couldn't tell you because I don't keep
20 records. I don't count, so I don't have an accurate
21 number.

22 Q. It's obviously more than a couple;
23 otherwise, you'd be able to say to me this is the
24 second time or the third time. So let me ask you in
25 sort of a ball park, are we talking more than ten

1 times?

2 A. Probably more than ten times.

3 Q. Are we talking more than 100?

4 A. Again, I'd just be guessing. I don't
5 know.

6 Q. More than 20 times?

7 A. Again, I'd just be guessing. I don't
8 know.

9 Q. Where do you keep records concerning your
10 prior cases that you served as an expert witness?

11 A. Don't keep records.

12 Q. What do you intend to do with these
13 records following this case?

14 A. Throw them out.

15 Q. Where do you maintain these records
16 currently, other than right in front of you?

17 A. My house.

18 Q. Is that where you keep your records for
19 medical malpractice cases?

20 A. Yes.

21 Q. How many cases are you currently
22 reviewing as an expert witness?

23 A. I don't know. I don't count.

24 Q. More than just this case?

25 A. For medical malpractice? Yes.

1 Q. More than a half a dozen cases that
2 you're currently reviewing?

3 A. Again, I haven't counted, so I couldn't
4 tell you.

5 Q. You've been deposed before, haven't you?

6 A. Yes.

7 Q. And you've been asked this question
8 before, haven't you?

9 A. Yes.

10 Q. And having been asked this question
11 before, did you ever stop and think you might want to
12 be able to respond in terms of numbers?

13 A. Actually, I've stopped and thought about
14 it and decided I don't want to respond to numbers.

15 Q. Your address is 33 -- is it Rebellion
16 Road?

17 A. Yes.

18 Q. Is that your home address?

19 A. Yes.

20 Q. Where is your office located?

21 A. 171 Ashley Avenue.

22 Q. Is that a medical building?

23 A. It's the Medical University Hospital.

24 Q. I'm sorry?

25 A. It's the Medical University Hospital.

1 Q. Is that where you see patients on an
2 outpatient basis?

3 A. No, we have two facilities. One is a few
4 blocks away, and one is a couple of miles away.

5 Q. Where do you see your patients, or does
6 it vary between the two offices on an outpatient
7 basis?

8 A. Monday afternoons it's up in North
9 Charleston, and all day Thursdays it's at the
10 building three blocks away from the hospital.

11 Q. Do you have partners in your practice?

12 A. Yes.

13 Q. Who are the doctors?

14 A. Dr. Angus McBryde, Dr. Langdon Hartsock,
15 Dr. Del Schutte, Dr. Keith Merrill, Dr. John
16 McFadden, Dr. David Tate, Dr. Dick Gross, Dr. Carl
17 Stanitski, Dr. Debbie Stanitski. I think that's it.

18 Q. Is there a reason that your letter is
19 written on personal stationery as opposed to
20 professional stationery?

21 A. This is something separate from my
22 practice at the hospital. I keep it separate.

23 Q. And what percentage of your time would
24 you say that you devote to serving as a medical
25 witness?

1 A. Again, I've never figured numbers, but
2 it's obviously small to tell you -- to outline to
3 you. I have a busy practice during the week.
4 There's only so many hours in the day.

5 Q. You can't answer that question?

6 A. Other than how I have, no.

7 Q. How many years have you been serving as
8 an expert witness?

9 A. I think the first time I got asked -- I
10 don't remember exactly the case. Early '90s.

11 Q. How many cases do you review on average
12 in any given year?

13 A. Again, I don't know because I don't
14 count. I don't keep track.

15 Q. Are we talking a half a dozen, or are we
16 talking close to 20 cases?

17 A. Again, I don't count. I don't have
18 accurate numbers. I'm not going to guess.

19 Q. Can you give me an estimate?

20 A. No.

21 Q. Do you review more than two or three
22 cases a year?

23 A. Yes.

24 Q. Do you review more than six cases a year,
25 one every two months?

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1 A. Probably, yes.

2 Q. Do you review more than one case a month?

3 A. Again, I don't know.

4 Q. How many times have you testified in this
5 type of a setting, in a deposition as opposed to in
6 the courtroom?

7 A. Again, I don't keep track. I don't
8 count, so I couldn't answer that.

9 Q. You've been doing this since the early
10 '90s, if we use that sort of as a landmark?

11 A. As I said, I think the first time I was
12 asked to review a case as an expert was the early
13 '90s. I don't remember if that went to deposition or
14 not.

15 Q. Let's just take the predicate that you
16 haven't been doing this any longer than eight or nine
17 years. Is that a fair statement?

18 A. Seven, eight years.

19 Q. And do you testify by way of deposition
20 more than once a year?

21 MR. TRAVIS: Can I have a clarification?
22 Are you talking about cases where a patient is
23 injured --

24 MR. MISHKIND: I'm talking about medical
25 malpractice cases.

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1 THE WITNESS: Sometimes it's less than
2 once a year. Sometimes it's more than once a year.
3 It varies.

4 BY MR. MISHKIND:

5 Q. When was the last time you were deposed
6 in a medical malpractice case?

7 A. I think it was February, March of this
8 year.

9 Q. What was the name of that case?

10 A. I think Butler was the patient.

11 Q. What state?

12 A. South Carolina.

13 Q. Who was the doctor?

14 A. Woodward.

15 Q. Spell the last name, please.

16 A. Woodward.

17 Q. Down here in Charleston?

18 A. The doctor was from Columbia. The
19 deposition took place down here in Charleston.

20 Q. When are you next scheduled to give
21 deposition testimony in a case?

22 A. A malpractice case?

23 Q. Yes.

24 A. I think I've got a deposition in August
25 or September for a case in Florida.

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1 Q. What's the name of that case?

2 A. I think it's Hiney versus Alter,
3 H-I-N-E-Y.

4 Q. Are you the expert for the patient or the
5 expert for the doctor?

6 A. In both of those, I was for the defense.

7 Q. Do you recall the name of the attorneys
8 or any of the attorneys in those cases?

9 A. Yeah, I should know the guy's name up in
10 Columbia. The firm is Richardson, Plowden. George
11 Beighley was the attorney up in Columbia. I can't
12 remember the attorney in Florida.

13 Q. Is Mr. Beighley the attorney for the
14 doctor?

15 A. Yes. That case was settled a couple of
16 months ago.

17 Q. Did either of those cases involve
18 shoulder surgery?

19 A. The one in Columbia did not. The one in
20 Florida does.

21 Q. What part of the state of Florida did the
22 surgery take place in?

23 A. I don't recall, but the lawyer is based
24 in Orlando.

25 MR. TRAVIS: Just answer the question.

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1 BY MR. MISHKIND:

2 Q. Were both lawyers from Orlando, Florida,
3 plaintiff's and the doctor's lawyer?

4 A. I don't recall.

5 Q. That case did involve a shoulder surgery?

6 A. Yes.

7 Q. Did it have -- was it a hemiarthroplasty?

8 A. I can't recall the specifics of it.

9 Q. How many times have you testified,
10 Doctor, actually in a courtroom as an expert witness
11 in a medical malpractice case?

12 A. To the best of my recollection, four or
13 five -- in medical malpractice?

14 Q. Yes.

15 A. Three or four times, if I can remember.

16 Q. When is the last time you testified in a
17 courtroom in a medical malpractice case?

18 A. Last fall.

19 Q. Where?

20 A. Orlando.

21 Q. What was the name of that case?

22 A. I don't remember.

23 Q. Who was the attorney or the name of one
24 of the attorneys that was involved in that case?

25 A. The attorney I remember was Mr. Richards

1 Ford.

2 Q. Richards was his first name?

3 A. Yes.

4 Q. And were you testifying on behalf of the
5 patient or on behalf of the doctor?

6 A. For the defendant, the doctor.

7 Q. Aside from medical malpractice cases, do
8 you serve as an expert witness in connection with
9 other orthopedic matters?

10 A. What do you mean by other orthopedic
11 matters?

12 Q. Non-medical malpractice matters, injury
13 cases.

14 A. Yes, and I've been involved in one patent
15 infringement lawsuit.

16 Q. Okay. How frequently are you asked to
17 give testimony as an orthopedic surgeon in connection
18 with injury-related cases?

19 A. Not very frequently.

20 Q. Do you do what's known as independent
21 medical examinations?

22 A. Occasionally do those in the office, yes.

23 Q. When you say occasionally, how frequently
24 do you do them?

25 A. Less than one a week.

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1 Q. How many different insurance companies do
2 you do work for in connection with these independent
3 medical exams?

4 A. Don't really know. I mean, a lot of
5 times they call and make an appointment. It's all
6 done through scheduling, and I just see the patient
7 and render an opinion. I don't know where it's
8 coming from,

9 Q. Do you know the names of any of the
10 insurance companies that you do work for?

11 A. A lot of times the patients come with
12 rehab nurses, so I may not be aware of the companies.
13 But to mind, I think Allstate and State Farm.

14 Q. By the way, who is your medical
15 malpractice carrier?

16 MR. TRAVIS: Objection. You can answer.

17 THE WITNESS: We're insured by the State
18 of South Carolina.

19 BY MR. MISHKIND:

20 Q. It's not an independent company?

21 A. No.

22 Q. Doctor, in terms of the work that you do
23 as a witness in medical malpractice cases, what
24 percentage of the time have you given testimony on
25 behalf of the patient, and what percentage of the

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1 time on behalf of the doctor being sued?

2 A. For testimony, it's probably -- maybe
3 60/40, 70/30 for defense.

4 Q. And you've been asked that question
5 before by other attorneys, correct?

6 A. Yes.

7 Q. And in terms of review of cases, how
8 would you define the breakdown between plaintiff and
9 defendant?

10 A. My impression is probably 50/50.

11 Q. And, again, that question has been asked
12 of you as well in the past, correct?

13 A. I believe so, yes.

14 Q. And have the numbers changed in terms of
15 the percentages in the last year or two?

16 A. My impression is a little more for the
17 defense, yes.

18 Q. Have you ever testified in a case similar
19 to Nancy Dunham where there was a complication
20 following a hemiarthroplasty?

21 A. No.

22 Q. Doctor, do you provide your name to any
23 companies that locate expert witnesses for attorneys?

24 A. One company.

25 Q. What's the name of that company?

A. WILLIAM ROBERTS, JR., & ASSOCIATES

RICHARD J. FRIEDMAN, M.D. - EX. BY MR. MISHKIND

1 A. Dr. Stephen Learner & Associates.

2 Q. And how long have you provided your name
3 through Dr. Learner's company?

4 A. Three years.

5 Q. Any other companies that you provide your
6 name through?

7 A. No.

8 Q. Have you in the past provided your name
9 through any other expert search firms or expert
10 witness companies?

11 A. No.

12 Q. Have you ever advertised independently in
13 any publications your availability as an expert
14 witness in medical malpractice cases?

15 A. No.

16 Q. When were you first contacted by
17 Mr. Travis?

18 A. I believe in February of this year.

19 Q. There's a letter that's in front of you.
20 By the way, do you have all of your correspondence
21 that Mr. Travis has sent to you?

22 A. I believe so, yes.

23 Q. You said that you maintain this material
24 at your home, correct?

25 A. Yes.

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1 Q. And when the material was sent to you by
2 Mr. Travis, it was sent to you at your home, not at
3 your offices, correct?

4 A. Correct.

5 Q. Is there anything that relates to Nancy
6 Dunham back at your home that you didn't bring with
7 you today?

8 A. No.

9 Q. Was there anything that was removed by
10 Mr. Travis that was in the material that is in front
11 of you today before this deposition started?

12 A. No.

13 Q. So all of the correspondence that you
14 have, that you've received from Mr. Travis, is in
15 front of you?

16 A. Oh, I think I threw out a cover letter
17 that came with a check covering this deposition.
18 Other than that, everything I've been sent is here.

19 Q. How is it that Mr. Travis obtained your
20 name? Was it through Stephen Learner & Associates?

21 A. No.

22 Q. How did he obtain your name?

23 A. I don't know.

24 Q. What did he indicate to you when he
25 called you?

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1 A. I believe he asked me if I'd review a
2 case, gave me the specifics -- some of the specifics,
3 and I said, okay and told him where to send the
4 materials.

5 Q. And did you make any notation of that
6 conversation anywhere?

7 A. No.

8 Q. Since you provide your service through
9 this company, I presume you asked him how it was that
10 he obtained your name?

11 A. No, actually, I didn't.

12 Q. Do you have any knowledge as to how he
13 obtained your name?

14 A. No, I don't.

15 Q. Even as you sit here now, did you ever
16 ask him how you happened to come upon me?

17 A. I don't know how he got my name.

18 Q. Now, what was it specifically that
19 Mr. Travis asked you to do in connection with this
20 case?

21 A. To the best of my recollection, he asked
22 me if I'd review the records and offer an opinion as
23 to whether Dr. Ghanma deviated or violated from the
24 standard of care.

25 Q. How would you define that term, standard

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1 of care?

2 A. I would define that as what one would
3 expect from an average orthopedic surgeon practicing.

4 Q. I don't see in any of the correspondence
5 any specific issues identified by Mr. Travis in the
6 letters. Did you make any notation when you were
7 reviewing the case of any of the specific issues that
8 he was looking for you to address?

9 A. I made some notations. They weren't
10 necessarily anything that he asked specifically, I
11 sometimes just jot some points down as I'm going
12 along that I wonder about or need to look up after
13 that may or may not get answered.

14 Q. I notice on the back of several of the
15 letters that you have some handwritten entries. Are
16 those in your handwriting?

17 A. Yes.

18 Q. Are there other notes that you made that
19 you have since discarded?

20 A. No.

21 Q. So everything that you have written down
22 you have with you today?

23 A. Yes.

24 Q. When you prepared the report, did you
25 type it yourself?

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1 A. Yes.

2 Q. Did you do it on a computer?

3 A. Yes.

4 Q. Was this a work in progress as you were
5 reviewing the material?

6 A. I'm not sure what you mean.

7 Q. Did you just sit down one day and compose
8 the letter, or did you compose it as you were
9 reviewing the material?

10 A. I sat down one day and composed the
11 letter.

12 Q. Can we agree, Doctor, that the vast
13 majority of three- or four-part fractures, the
14 humeral component is secured with cement to achieve
15 stability?

16 A. In the majority of cases, I would say
17 that's correct, although there are certainly people
18 who talk about using a press fit technique and not
19 using cement.

20 Q. And you're looking actually to achieve
21 what's known as rotational stability, correct?

22 A. That's one type, yes.

23 Q. The type of surgery that Dr. Ghanma did
24 in this case, is this the type of surgery that you
25 use in approaching a three- or four-part fracture in

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1 a patient that is 66 years old with the medical
2 history that Mrs. Dunham had?

3 A. Yes.

4 Q. You would have approached the surgery in
5 terms of the same operative technique?

6 A. Similar, yes.

7 Q. How would it have differed?

8 A. I may have cemented the prosthesis.
9 That's a judgment you make at the time, if you think
10 it's stable enough. If it's stable, it's perfectly
11 okay to press fit it. If it's not stable, then you'd
12 cement it.

13 Q. How many hemiarthroplasties do you
14 perform during any given year?

15 A. Again, I don't count or keep track, but
16 we do -- are you talking about for fractures?

17 Q. Yes.

18 A. Probably a rough guesstimate, one a
19 month, maybe a little more.

20 Q. Now, you said we. I'm talking about you
21 personally.

22 A. One a month.

23 Q. Would you describe what Dr. Ghanma did as
24 a Neer-type hemiarthroplasty?

25 A. Okay, yes.

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1 Q. Well, I don't -- if I'm not using the
2 proper reference, then correct me. Don't agree with
3 me just to be cooperative.

4 A. No, I think that's an okay description.

5 Q. The one per month that you do in terms of
6 hemiarthroplasties for fractures, how long have you
7 been doing on average one a month?

8 A. I would say a number of years, but I
9 can't give you a specific number.

10 Q. Before the 1990s, or is it just in the
11 1990s?

12 A. Probably the 1990s. I mean, I started
13 practicing in '86, and obviously volume grows as time
14 goes on.

15 Q. How about the number of
16 hemiarthroplasties that you do for three- or
17 four-part fractures, or is that the same one?

18 A. It's the same thing.

19 Q. Okay. In fact, if it was less than a
20 three-part, you wouldn't necessarily be doing a
21 hemiarthroplasty, would you?

22 A. Correct, and for some three-parts, we
23 treat them differently.

24 Q. And some are actually treated in a
25 conservative manner without surgical intervention,

1 correct?

2 A. Correct.

3 Q. By the way, I asked you how you were
4 introduced to Mr. Travis, and you can't tell me how
5 that was. Can you tell me whether you are reviewing
6 any other cases for him or anyone at his law firm of
7 Gallagher, Sharp?

8 A. I don't believe so.

9 Q. Have you at any time done any work for
10 any other attorneys at the Gallagher, Sharp law firm?

11 A. I don't believe so.

12 Q. Have you ever reviewed a case for any
13 attorneys up in the Cleveland, Ohio, area, other than
14 Mr. Travis?

15 A. I may have, but I can't remember
16 specifically.

17 Q. What about in the state of Ohio?

18 A. I may have. I can't remember
19 specifically.

20 Q. If you wanted to know who you've worked
21 with, do you maintain any type of record on a case,
22 or do you, once you're done with a case, just dispose
23 of the material and forget about it?

24 A. Dispose of the material and forget about
25 it.

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1 Q. And just wash your memory of any contact
2 with that lawyer or the case or the location?

3 A. That's correct.

4 Q. So I guess the only records we would have
5 relative to your involvement would be payment records
6 that you receive for services in connection with the
7 cases, correct?

8 A. Correct.

9 Q. Because, obviously, you've got to report
10 that as income in your taxes?

11 A. I report all the 1099s that are sent to
12 me, that's correct.

13 Q. Let me see the correspondence. You have
14 a notebook, Doctor, black notebook that has a number
15 of items, and I believe that the items include
16 Dr. Ghanma's office chart, Elyria Memorial Hospital
17 records, Cleveland Clinic Foundation records, and
18 then records from a Dr. Viswanath and a
19 Dr. Carandang, and CVC Pharmacy records. Is that
20 correct?

21 A. Yes.

22 Q. You also received the deposition of
23 Dr. Ghanma and Mr. And Mrs. Dunham?

24 A. Yes.

25 Q. And apparently just recently you received

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1 the deposition of Dr. Kay?

2 A. Yes.

3 Q. Have you read Dr. Kay's deposition?

4 A. Yes.

5 Q. Other than the x-rays, have you received
6 and reviewed any other information in connection with
7 this case?

8 A. No.

9 Q. Now, contained in the Cleveland Clinic
10 records are Dr. Brems' records and his letter that he
11 wrote to Dr. Ghanma, correct?

12 A. It's in here, yes.

13 Q. Do you know Dr. Brems?

14 A. Yes.

15 Q. How do you know Dr. Brems?

16 A. Professionally, we met at meetings,
17 talked to each other.

18 Q. Have you ever had an opportunity to talk
19 to Dr. Brems concerning this case?

20 A. No.

21 Q. By the way, have you ever talked to or
22 met Dr. Ghanma?

23 A. No.

24 (PLF. EXH. 1, 2/4/99 Letter to Dr.

25 Friedman From D. John Travis, was marked

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1 for identification.)

2 (PLF. EXH. 2, 2/22/99 Letter to Dr.

3 Friedman From D. John Travis, was marked

4 for identification.)

5 (PLF. EXH. 3, 6/22/99 Letter to Dr.

6 Friedman From D. John Travis, was marked

7 for identification.)

8 BY MR. MISHKIND:

9 Q. Doctor, I've marked for identification
10 three letters to you from Mr. Travis dated February
11 4, February 22nd, and June 22nd, 1999, respectively.
12 And on the back of each of these letters is
13 handwriting by you, correct?

14 A. Yes.

15 Q. When did you make theses notes?

16 A. They would have been the time I was
17 reviewing the records, as I reviewed them.

18 Q. On the back of this February 22nd note, a
19 letter, you have notes from your read of the Dunham
20 and Ghanma depositions, correct?

21 A. Correct.

22 Q. And is this one page all that you marked
23 down when you read through those three depositions?

24 A. As you've asked that, I've already
25 answered, this is all that I have.

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1 Q. Again, I want to make sure as I'm looking
2 at your notes now. This is the one and only page of
3 notes that you made as you read over the depositions
4 of those three individuals?

5 A. Yes, the two.

6 MR. TRAVIS: You said two?

7 THE WITNESS: The Dunhams and Dr. Ghanma.

8 BY MR. MISHKIND:

9 Q. And then at the very bottom, you have a
10 note here, 3 3/4, plus report 1 1/41 which equals
11 five hours, plus talk, 1/4, equals 5 1/4 hours. I
12 assume that's for billing purposes?

13 A. Yes.

14 Q. What did you bill -- or what have you
15 billed Mr. Travis on an hourly basis for your review
16 in this case?

17 A. Again, I charge -- I bill \$500 an hour.
18 I don't keep track of the total. He would have that.
19 But, obviously, for all that, it came to 5 1/4 times
20 500.

21 Q. And then this letter of June 22nd, you
22 have notes on the back of that letter which I presume
23 relate to your read of Dr. Kay's deposition?

24 A. Yes.

25 Q. And, again, is this all that you have

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1 written concerning your review of Dr. Kay's
2 deposition?

3 A. Yes.

4 Q. And, again, at the very bottom, you have
5 1 3/4 hours plus 1/4 hour talk for a total of two
6 hours?

7 A. Yes.

8 Q. And that was billed at the rate of \$500
9 an hour?

10 A. Yes.

11 Q. Now, at the bottom of this note, it says,
12 tell Travis about my two BA something. I can't
13 decipher --

14 A. TSA books.

15 Q. My two...

16 A. TSA.

17 Q. Okay, what is TSA?

18 A. Total shoulder arthroplasty.

19 Q. Why did you make that note, tell Travis
20 about my TSA books?

21 A. To let him know that I wrote two books on
22 shoulder replacements.

23 Q. And what are the names of those books?

24 A. One is called *Arthroplasty: The*
25 *Shoulder*. And the other one is actually an issue of

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1 *Orthopedic Clinics of North America* that dealt with
2 total shoulder arthroplasty.

3 Q. Why, when you were reviewing Dr. Kay's
4 deposition, did you make a note to tell Mr. Travis
5 about these two books?

6 A. Just thought it was relevant, he'd
7 probably want to know about it.

8 Q. Is there anything in particular in those
9 two books that you felt Mr. Travis should be aware
10 of?

11 A. No.

12 Q. You have various people that have
13 contributed different sections to those books,
14 correct?

15 A. Yes.

16 Q. And certainly you would consider the
17 contributors to your books to be well-respected and
18 well-regarded orthopedic surgeons?

19 A. Yes.

20 Q. And the subject matter of their various
21 sections, you would deem those to be reliable and
22 authoritative?

23 MR. TRAVIS: Objection. **If** you
24 understand the question, you can answer.

25 THE WITNESS: I would deem the authors to

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1 be people who have experience in those areas.

2 BY MR. MISHKIND:

3 Q. What about the topics that are covered,
4 do you consider what they have said on the topics to
5 be accurate and reliable?

6 MR. TRAVIS: I'm going to object unless
7 you present him with a specific article he can
8 comment on. You can answer if you can, Doctor.

9 THE WITNESS: Again, I think that each
10 article reflects the author's beliefs and opinions at
11 the time that it was written.

12 BY MR. MISHKIND:

13 Q. Are you saying there are certain beliefs
14 and opinions by authors in your textbooks that you
15 don't necessarily agree with?

16 A. No. I think more what I'm saying is that
17 things change over time. So something that may have
18 been written a number of years ago may not
19 necessarily be true today.

20 Q. I note at the bottom here: M.D. made a
21 reasonable judgment call at the time. Just because
22 it doesn't turn out correct, doesn't equal negligence
23 or deviation.

24 Did I read that correctly?

25 A. I believe so, yes.

1 Q. And you would certainly recognize that
2 simply because you label something as a judgment
3 call, doesn't mean that it isn't necessarily below
4 the standard of care?

5 A. Would you repeat that?

6 Q. Sure. If a doctor exercises judgment in
7 approaching something, in your opinion, does that
8 always excuse him from being responsible for having
9 deviated from accepted standards of care?

10 A. No.

11 Q. There are judgments that a doctor
12 demonstrates in the treatment of a particular
13 situation that can amount to substandard care or
14 negligence, correct?

15 A. Yes.

16 Q. So even though the doctor may have
17 exercised what he considered to be reasonable
18 judgment in a given circumstance, you wouldn't
19 necessarily say to a jury that because he exercised
20 what he considered to be reasonable judgment, that he
21 was therefore free of substandard care?

22 A. That's correct.

23 Q. I'm going to talk to you a little bit
24 further about this one when we get to that. In fact,
25 I'm going to have you decipher some of your

1 handwriting. Some of it I can read, believe it or
2 not. You met with Mr. Travis for approximately two
3 hours before this deposition, correct?

4 A. Yes.

5 Q. And what did you and he discuss during
6 that meeting?

7 A. We just went over some of the facts of
8 the case, went over some of the x-rays. That's about
9 it.

10 Q. Did Mr. Travis share with you his theory
11 of liability in this case?

12 MR. TRAVIS: Objection. Are you assuming
13 I have a theory of liability? You can answer if you
14 can.

15 THE WITNESS: No.

16 BY MR. MISHKIND:

17 Q. Did he share with you what the theory is,
18 the plaintiff's theory in this case?

19 A. No.

20 Q. When did you first meet Mr. Travis?

21 A. Approximately 11 a.m. this morning.

22 Q. Had you met him before 11 a.m. today?

23 A. No.

24 Q. You talked to him, obviously, on the
25 phone, but this is the first time you met him in

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1 person?

2 A. Yes.

3 Q. Now, your charge today for a deposition
4 is \$600 an hour, correct?

5 A. Correct.

6 Q. And I believe I was required to pay you
7 an advance payment a certain number of weeks ahead of
8 time in the amount of two hours as an advance
9 payment, correct?

10 A. Yes.

11 Q. What is your charge when you come to
12 Cleveland or northeastern Ohio to testify in Lorain
13 County for purposes of this case?

14 A. It's \$600 an hour for a minimum eight
15 hours of one day, which would be 4800, plus expenses.

16 Q. In the number of hemiarthroplasties that
17 you've done for three- or four-part proximal humeral
18 head fractures, how many have you had where two to
19 three weeks after surgery, the greater tuberosity had
20 avulsed?

21 A. Are you talking about ones that I did or
22 ones that got referred in to me after they were done?

23 Q. Ones that you have done.

24 A. I had one recently, and other than that,
25 I can't think of one where that's happened.

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1 Q. Tell me about that patient.

2 A. It was a 51-year-old gentleman who was
3 involved in a high speed motor vehicle accident, and
4 he sustained -- I think it was a four-part fracture,
5 amongst numerous other injuries, including a broken
6 neck. We went ahead and did a hemiarthroplasty. And
7 at some point between two weeks and six weeks, he
8 pulled his tuberosities off.

9 Q. How did you treat that situation?

10 A. We waited about two months until his neck
11 fracture healed, and then we took him back and
12 reoperated on him.

13 Q. The determining factor in terms of
14 waiting was the neck fracture?

15 A. That was a big part of it, yes, and his
16 other overall medical condition and problems.

17 Q. If he didn't have the neck fracture and
18 other medical problems, I presume associated with the
19 injury, would you have gone back in and operated
20 sooner?

21 A. Yes.

22 Q. If a decision is made to do a secondary
23 surgery -- to perform a secondary surgery following a
24 failed hemiarthroplasty, is it better to do the
25 secondary surgery early on as opposed to on a delayed

1 basis?

2 A. I think, in general, the earlier you do
3 something, the better the result is going to be.

4 Q. And from the standpoint of the shoulder
5 and treating a failed hemiarthroplasty, why is, as a
6 general rule, better -- why as a general rule is
7 earlier better than waiting?

8 A. Well, I think that's true for any body
9 part. In the shoulder specifically, the function and
10 outcome is very dependent on the soft tissues, and
11 you get a lot of scarring and healing that occurs as
12 time goes on, which is something you have to deal
13 with. And if you can get to it before that happens,
14 you have a chance of getting a better result.

15 Q. In the situation with this gentleman
16 where you went in after his neck condition was
17 stabilized and did a secondary repair, did you do
18 another hemiarthroplasty?

19 A. No, we just went ahead and reattached the
20 tuberosities and the rotator cuff as best as we
21 could.

22 Q. And how is he doing functionally?

23 A. He is doing much better now than he was,
24 yes.

25 Q. In terms of his pain and his limitations

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1 in terms of active range of motion, where is he at
2 now?

3 A. I'm not sure what you mean, where is he
4 at now.

5 Q. Is he experiencing less pain than he was
6 following the avulsion of the greater tuberosity?

7 A. Yes.

8 Q. Is he pain-free?

9 A. I don't recall if he's pain-free, but
10 he's certainly much less painful than he was.

11 Q. In terms of the range of motion that he
12 has achieved as a consequence of your doing the
13 secondary repair, does he have increased range of
14 motion over what he had when the greater
15 tuberosity -- the avulsion of the greater tuberosity
16 was discovered?

17 A. Yes.

18 Q. Do you know offhand what his range of
19 motion is now?

20 A. I don't recall.

21 Q. Would you agree that meticulous surgical
22 technique is essential to prevent complications at
23 the time of a hemiarthroplasty?

24 A. I think meticulous technique is essential
25 to minimize the complications.

1 Q. Would you agree that factors that
2 correlate with poor post-op results include
3 tuberosity nonunion and malunion?

4 A. Yes.

5 Q. Putting aside your case with the
6 gentleman from the high-speed crash, you said that
7 you've also had patients referred to you where you've
8 gone in and done secondary repairs, correct?

9 A. Yes.

10 Q. How many secondary repairs have you done
11 following failed hemiarthroplasties?

12 A. Again, I can't give you an accurate
13 number, but there have been a number of them.

14 Q. Again, just so that I have some context,
15 are we talking more than a dozen or less than a
16 dozen?

17 A. More than a dozen.

18 Q. More than two dozen?

19 A. Over the years I've been in practice, I
20 would just be guessing.

21 Q. So certainly more than a dozen, but you
22 can't be any more specific than that?

23 A. Correct.

24 Q. Of those cases, has the success in terms
25 of reduction in pain and increase in range of motion

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1 been greater the earlier that you've gotten in to do
2 the secondary repair following the failed
3 hemiarthroplasty?

4 A. I haven't reviewed those patients and
5 looked at that specifically, so I can't give you an
6 accurate answer.

7 Q. The ones that you have done secondary
8 surgery on, have they been trauma cases?

9 A. Right. We're talking about three- and
10 four-part fractures.

11 Q. Correct, okay. So you're excluding any
12 avascular necrosis and arthritic cases. You're
13 dealing in the context of trauma?

14 A. Correct.

15 Q. Okay, fine. I just want to make sure
16 we're on the same page. The failed
17 hemiarthroplasties, have they been in large part due
18 to avulsion of the greater tuberosity?

19 A. I think some have been avulsions. Some
20 have been malunions.

21 Q. Is it sometimes difficult to detect the
22 difference between an avulsion and a malunion of the
23 greater tuberosity?

24 A. Let me add, some have also been
25 nonunions, so nonunions can be difficult to determine

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1 sometimes. Sometimes the anatomy is very distorted,
2 and it can be difficult to discern exactly what is
3 going on. And some of the usual x-ray tests that we
4 get are not helpful because of the presence of metal.
5 They distort the pictures, such as a CT scan. So you
6 have to make a clinical judgment and then decide a
7 large part while you're in there what needs to be
8 done and do it.

9 Q. Is it fair to say, though, that if you
10 suspect that there has been either an avulsion of the
11 greater tuberosity or a malunion or a nonunion of the
12 greater tuberosity, that the standard of care for an
13 orthopedic surgeon requires consideration of the
14 options that are available to treat that condition?

15 MR. TRAVIS: Can you read that back,
16 please?

17 BY MR. MISHKIND:

18 Q. I'll strike that. The doctor had a
19 quizzical look on his face. Would you believe the
20 standard of care requires that the surgeon recognize
21 as promptly as one can that there has either been an
22 avulsion, malunion, or nonunion of the greater
23 tuberosity?

24 A. Yes.

25 Q. And once having recognized that there is

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1 some process going on that is not what had been
2 planned and not what appeared to exist at the time of
3 the surgery, would you agree that the surgeon has to
4 consider the method of treatment, surgical versus
5 conservative?

6 MR. TRAVIS: Objection, compound
7 question. You can answer if you can.

8 THE WITNESS: Yes.

9 BY MR. MISHKIND:

10 Q. And would you agree that, ultimately,
11 it's the patient that has to make the decision as to
12 whether or not to have surgery or to be treated on a
13 conservative basis?

14 A. Repeat the question.

15 (The Court Reporter read the question
16 commencing on page 51, line 10, and concluding on
17 page 51, line 13.)

18 THE WITNESS: I think the patient
19 ultimately makes the decision, if surgery has been
20 recommended, whether to have it or not, that's
21 correct.

22 BY MR. MISHKIND:

23 Q. It's the physician's obligation to
24 explain to the patient first what the condition is,
25 correct?

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1 A. Yes.

2 Q. And that being a complication that has
3 occurred subsequent to the hemiarthroplasty?

4 A. Assuming it's occurred, yes.

5 Q. And then the physician has an obligation
6 to explain to the patient the various methods of
7 treating that complication that has occurred since
8 the time of the hemiarthroplasty, correct?

9 A. To a certain degree, yes.

10 Q. And, ultimately, if one of the methods of
11 treatment would include surgery, the physician has to
12 explain the risks and benefits of undergoing surgery
13 to treat a failed hemiarthroplasty, correct?

14 MR. TRAVIS: Objection to the abstract
15 hypothetical question. You can answer if you can,
16 Doctor.

17 THE WITNESS: Yes.

18 BY MR. MISHKIND:

19 Q. And would you agree that if the physician
20 does not explain to the patient the risks and
21 benefits of undergoing surgery once a failed
22 hemiarthroplasty has been discovered, that that would
23 not be in keeping with accepted standards of care?

24 A. **If** the physician is proposing surgical
25 intervention, then I think the standard of care

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1 dictates that he explain what the options of the
2 surgery are, what the risks, the benefits are.

3 Q. You would certainly agree that the
4 patient is entitled to understand whether or not
5 surgery is an option for the treatment of a failed
6 hemiarthroplasty, correct?

7 A. If the physician considers it to be an
8 option, yes.

9 Q. Even though the physician or the surgeon
10 may not necessarily be recommending that, if the
11 physician feels that that is an option, the physician
12 has a duty and obligation to explain what the methods
13 of treatment are and why he's recommending one as
14 opposed to another, correct?

15 A. Well, it depends if you think it's an
16 option in that patient or it's just an option that
17 exists but wouldn't be applicable in that patient.

18 Q. No, an option in that particular patient,
19 but the doctor doesn't necessarily recommend it. He
20 certainly still has an obligation to explain the
21 options and why he's recommending one course of
22 treatment as opposed to another, correct?

23 A. In general, that's correct.

24 Q. When you reviewed the films -- you had a
25 chance to look at the original films before today's

1 deposition, correct?

2 A. Yes.

3 Q. And, previously, you had seen copies of
4 the films?

5 A. Yes.

6 Q. Are any of the opinions that you have in
7 the case altered in any respect after having seen the
8 original films?

9 A. No.

10 Q. The original films back in January of
11 1995 show an avulsion of the greater tuberosity, do
12 they not?

13 A. They show -- which films are we talking
14 about?

15 Q. January 3 and January 10, 1995.

16 A. They show a change in the fragment
17 position compared to the one post-op film that I saw
18 from December the 18th, 1994.

19 Q. My specific question to you is, do they
20 show that the humeral -- that a bone fragment is
21 present superiorly between the acromion and humeral
22 head consistent with avulsion of a portion of the
23 greater tuberosity?

24 A. They do show a fragment of bone superior
25 to the humeral prosthesis. Given the fact that the

1 humeral head is still articulating or matching up
2 properly with the glenoid, then I would have to say
3 it does not involve the major part containing the
4 rotator cuff, because if it did, then I would expect
5 the humeral prosthesis to be riding high, which it's
6 not.

7 Q. Which film are you looking at?

8 A. The films of January 3rd, 1995.

9 Q. Look at the January 10 films, if you
10 would, also.

11 MR. TRAVIS: Is there a question?

12 BY MR. MISHKIND:

13 Q. Do those films show the humeral -- the
14 bone fragment present superiorly between the acromion
15 and the humeral head consistent with avulsion of a
16 portion of the greater tuberosity?

17 A. They show a piece of bone up there, and
18 it basically does not look to be changed from the
19 films a week earlier.

20 Q. Are they consistent with an avulsion of a
21 portion of the greater tuberosity?

22 A. I think they're a piece of the tuberosity
23 bone, I don't think they're a piece containing the
24 major rotator cuff portions.

25 Q. Again, my question is, are they

1 consistent with avulsion of a portion of the greater
2 tuberosity?

3 A. Yes.

4 Q. And when we refer to an avulsion of the
5 greater tuberosity or a portion of the greater
6 tuberosity, what does that mean?

7 A. A piece of the bone is pulled off.

8 Q. Your testimony, however, is that that
9 avulsion of a portion of the greater tuberosity was
10 not a significant part, portion of the greater
11 tuberosity?

12 A. Correct.

13 Q. What was causing the avulsion of a
14 portion of the greater tuberosity some two weeks
15 post-op?

16 A. I'm not sure I understand the question.

17 Q. Why was there an avulsion of the greater
18 tuberosity that was detected two weeks after
19 Dr. Ghanma's hemiarthroplasty?

20 A. Well, the piece moved. Again, I don't
21 know if that piece was ever secured down. As he
22 mentions, that there were a number of loose pieces
23 that he did not fix. And it may be that one of those
24 pieces that was not fixed had moved. It would have
25 moved because the patient was doing physical therapy

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1 and moving the shoulder. I can't tell if that was
2 one of those pieces or if it was a piece that was
3 secured down at the time of surgery and then moved
4 off.

5 Q. Your testimony, though, is that is not a
6 significant portion of the greater tuberosity?

7 A. Correct.

8 Q. And why do you say that?

9 A. Because if it was, then he would have no
10 cuff left attached -- sorry, she would have no cuff
11 left attached. The humeral head would rise up
12 against the face of the glenoid. And, clinically, it
13 would correlate -- the x-ray finding would correlate
14 with the clinical picture, which it does not.

15 Q. If this is a significant portion of the
16 greater tuberosity and it's discovered within a
17 two-week period following surgery, following
18 Dr. Ghanma's surgery, which was done in December of
19 1994, would you agree that secondary surgery to
20 correct a significant portion of the greater
21 tuberosity should have been considered at that point?

22 MR. TRAVIS: Objection to the question as
23 stated. You can answer if you can.

24 THE WITNESS: Again, I think you have to
25 look at the patient. Remember, we treat patients.

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1 We don't treat x-rays. I think you have to correlate
2 the radiographic findings with the patient's symptoms
3 and physical findings. Take all that into account,
4 plus the findings that you notice at the time of the
5 surgery to decide whether further surgery would be
6 indicated or not.

7 BY MR. MISHKIND:

8 Q. Well, let me try to give it to you a
9 little bit differently perhaps to try to get a more
10 exact answer from you. You do a hemiarthroplasty on
11 a patient for a three- or four-part fracture. By the
12 way, do you consider this a three- or four-part?

13 A. I think it was probably more three-part.

14 Q. You do a hemiarthroplasty for a
15 three-part proximal humeral head fracture. Assume
16 that the patient within a two-, three-week period
17 demonstrates radiographically an avulsion of a
18 significant portion of the greater tuberosity.
19 Further assume that the patient is symptomatic
20 pain-wise and does not -- is not getting the kind of
21 range of motion back that you would want two to three
22 weeks following your hemiarthroplasty. Under those
23 circumstances, hypothetically speaking, would you
24 agree that surgery should be considered to correct
25 this problem?

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1 MR. TRAVIS: Objection to the
2 hypothetical. You can answer if you can.

3 THE WITNESS: That's a lot of
4 hypotheticals. But I think if you have the scenario
5 that the patient was progressing along at a certain
6 pace and then something changed very suddenly and
7 they had lost the function that they had and they
8 were having significantly more pain than they had and
9 you had those radiographic findings, in a
10 hypothetical situation, then, yes, I would consider
11 surgical intervention.

12 BY MR. MISHKIND:

13 Q. So each case in terms of whether you want
14 to recommend secondary repair is going to depend upon
15 what has developed from the time of the surgery up
16 until the time that that avulsion of the greater
17 tuberosity has been discovered. Is that a fair
18 statement?

19 A. It's going to depend on that, plus also
20 the condition of the bone and the soft tissues that
21 you notice at the time of your initial surgery.

22 Q. Okay, Well, in terms of your article
23 that you did with Dr. Langdon and Hartsock and those
24 guys, you reviewed the success of total shoulder
25 arthroplasty in what you considered to be patients

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1 over 70 and patients under 70, didn't you?

2 A. I'd have to take a look at it. May I?

3 Q. You don't recall?

4 A. I don't recall that specifically, no.

5 Q. Okay. Would you agree that Mrs. Dunham's
6 age being less than 70 is a good factor in terms of
7 the probability of achieving a good functional
8 outcome?

9 A. I don't consider there to be a difference
10 between a 66-year-old and a 70-year-old in that case.

11 Q. You're familiar with Goldman and his
12 group and his studies?

13 A. Goldman?

14 Q. Goldman.

15 A. Not off the top of my head.

16 Q. You're familiar with Compito,
17 C-O-M-P-I-T-O, Dr. Compito?

18 A. Not off the top of my head.

19 Q. And you're not familiar off the top of
20 your head with Dr. Goldman?

21 A. No.

22 Q. You're not familiar with the report by
23 Dr. Goldman that showed that patients younger than 70
24 years had greater range of motion than older
25 patients?

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1 A. Was that in fractures or for arthritis?

2 Q. Fractures.

3 A. I don't recall the details, no.

4 Q. You would agree that in terms of
5 performing a secondary surgery on a failed
6 hemiarthroplasty, that the results in terms of going
7 back in and doing further surgery are better when the
8 surgery is performed within two weeks versus delayed?

9 A. I would say the earlier you do it, the
10 better your success rate. I'm not sure there is any
11 magic about two weeks. If it's 12 days or 16 days,
12 I'm not sure if there is any difference right there.
13 But, clearly, the earlier you do it, the better
14 chance you have of having a better result. But that
15 result would still always be less than you would have
16 gotten after a primary procedure.

17 Q. You would certainly agree, would you not,
18 that careful placement of the prosthesis and secure
19 reattachment of the greater tuberosity to the shaft
20 reduces the chances of complications following
21 surgery?

22 A. Yes.

23 Q. And good to excellent results in terms of
24 range of motion and pain relief can be expected in
25 most patients, correct?

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1 A. Well, it depends how you define good and
2 excellent results.

3 Q. How do you define it?

4 A. I think you have to define it differently
5 for different diagnostic groups. I think as a group,
6 patients with fractures do not do as well as patients
7 who are having hemiarthroplasties for arthritic
8 conditions. I think that they do better than other
9 traditional methods that were used before
10 replacements came along, but they're certainly not as
11 good as we would like them to be.

12 Q. Are there any studies that you are aware
13 of that you've participated in, presentations that
14 you've heard of, or anything out there in the medical
15 world that suggests that reoperation or secondary
16 surgery following a failed hemiarthroplasty always
17 results in less than what you expected to achieve
18 from the primary repair?

19 A. I can't quote you any references off the
20 top of my head.

21 Q. In your report I believe you opined that
22 results of reoperation are always less than those
23 following primary procedures. Correct?

24 A. Yes.

25 Q. But you can't give me any particular

1 studies that support that position, can you?

2 A. Not off the top of my head, no.

3 Q. Can we agree that there are circumstances
4 where reoperation is an appropriate option, even if
5 not as good as the primary procedure?

6 A. Yes, we do that all the time.

7 Q. And if in fact reoperation is an
8 appropriate option, even if not as good as the
9 primary procedure, a patient is entitled to the
10 benefit of having that reoperation, correct?

11 A. If the operation is indicated.

12 Q. Absolutely. Do you have a copy of the
13 American Shoulder and Elbow Surgeons evaluation form?

14 A. Here with me today?

15 Q. Yes.

16 A. No.

17 Q. Do you use that in your practice?

18 A. Sometimes.

19 Q. What is meant when it states that a
20 slightly performed prosthesis was done?

21 A. I think that's a typographical error. It
22 doesn't mean anything to me.

23 Q. When, in your opinion, Doctor, did
24 Mrs. Dunham tear her rotator cuff?

25 A. It is difficult to say. I don't know

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1 specifically when or in fact if she actually tore it
2 or it became dysfunctional.

3 Q. Do you intend to take the stand and
4 testify to a reasonable degree of medical probability
5 as to what stage of her recuperation she most likely
6 tore the rotator cuff?

7 A. You mean as to a specific date?

8 Q. Or a specific time in the convalescence?

9 A. I can't get very specific, but in
10 generalities, yes.

11 Q. What are the generalities that you can
12 provide?

13 A. I think it was probably sometime six
14 months, maybe longer, from after her surgery. So
15 we're talking late spring, summer, somewhere in
16 there, it ceased to function as it had been.

17 Q. And what was it that caused it to cease
18 to function in that manner?

19 A. She may have torn it, or it may have
20 ceased to function just because it was no longer able
21 to bear up to the loads that were being subjected to
22 it. I suspect that due to her age, her rotator cuff
23 was not normal to begin with before she had the
24 accident. It clearly got severely injured and
25 damaged because of the accident. And while repaired,

1 sometimes rotator cuffs just don't hold up.
2 Sometimes they're like tissue paper, and they might
3 stretch out and thin out, Sometimes they become like
4 wet tissue paper, just crumbles away, ceases to
5 function. Sometimes it just tears completely.

6 Q. If there is evidence of avulsion of the
7 greater tuberosity, how would that impact the rotator
8 cuff?

9 A. Well, I think when we're talking about
10 avulsion of the tuberosity, we're really talking
11 about avulsion of the rotator cuff tendons, which are
12 generally attached to the tuberosity or some fragment
13 of the tuberosity. So if those are avulsed, the
14 rotator cuff is no longer attached to the humeral
15 bone, then the patient loses all ability, basically,
16 to lift their arm up. The shoulder itself also may
17 become unstable. The prosthesis may ride high up
18 against the face of the glenoid, and the patient may
19 have pain.

20 Q. Is there a cause/effect relationship
21 between a disruption of the rotation cuff and an
22 avulsion of the greater tuberosity?

23 A. I'm not sure I understand the question.

24 Q. Does an avulsion of the greater
25 tuberosity lead to disruption of the rotator cuff?

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1 A. If that piece of tuberosity that gets
2 avulsed has a major part of the cuff on it, yes.

3 Q. So if there is an avulsion of a
4 significant portion of the greater tuberosity, do you
5 have to be concerned about an associated rotator cuff
6 injury as well?

7 A. Again, I think we're talking about the
8 same thing. But if you say there's an avulsion, the
9 clinically important thing is has the rotator cuff
10 become detached from the humerus. And sometimes it
11 may tear off with a piece of bone. Sometimes it may
12 not tear off with a piece of bone. Sometimes it may
13 tear elsewhere. It may stay attached where you fix
14 it, but it may give somewhere else. The important
15 point is it is no longer connected in a functional
16 way to the proximal humerus.

17 Q. Would you agree that if there is an
18 avulsion of a significant portion of the greater
19 tuberosity, there is an increased likelihood that
20 there will be disruption of the rotator cuff as well?

21 A. I think it depends if you have the cuff
22 attached to the bone and you secured the bone
23 tuberosity piece to the humeral shaft or if you
24 secured the actual tendon pieces to the humeral shaft
25 and not the bone.

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1 Q. Can you tell from Dr. Ghanma's surgery
2 which he did?

3 A. He did a bone-to-bone reattachment,

4 Q. Now, taking that into account, if you
5 have an avulsion of a significant portion of the
6 greater tuberosity, is that likely to lead to
7 disruption of the rotator cuff?

8 A. If that's the piece that had the rotator
9 cuff attached to it, yes.

10 Q. Is that something that you need to be
11 aware of as a potential complication, either at the
12 time that the avulsion is discovered or in the
13 ensuing weeks or months thereafter?

14 A. Yes.

15 Q. So it's foreseeable, if in fact that's
16 the area where the rotator cuff was attached, that if
17 you discover an avulsion of the greater tuberosity
18 down the road, you are going to develop a disruption
19 of the rotator cuff as well?

20 A. It's a possibility.

21 Q. Now, there is no evidence in this case
22 that Mrs. Dunham had a shredded rotator cuff at the
23 time of Dr. Ghanma's surgery, is there?

24 A. Well, again, you may be arguing semantics
25 and descriptive terms. It depends what you mean by

1 shredded.

2 Q. Do you see anything that evidences -- how
3 would you describe a shredded rotator cuff?

4 A. Tears with ends that are frayed loose,
5 torn off from bone,

6 Q. And do you see any evidence that she had
7 a shredded rotator cuff at the time of her surgery?

8 A. Under my description, that's usually what
9 it looks like, yes.

10 Q. But does that automatically mean that the
11 patient is going to have a bad functional outcome if
12 the procedure is done properly?

13 A. No, it does not automatically mean that.

14 Q. When you do a surgery, a hemiarthroplasty
15 on a patient in their 60s or 70s, you expect to have
16 some osteoporosis, correct?

17 A. It's very common, yes.

18 Q. Is there anything about Mrs. Dunham's
19 pre-surgical medical history that in any way
20 decreased the likelihood of her having a good or
21 acceptable functional outcome after the surgery?

22 A. I would say she had significant
23 osteoporosis for a 66-year-old lady.

24 Q. On what do you base that?

25 A. I base that on two things. Number one,

1 just looking at the x-ray, you can see that her bones
2 are very osteoporotic. Number two, she has a number
3 of spine x-rays through the years that document
4 osteoporosis going back when she was in her early 50s
5 and probably more than what one would expect for the
6 average 50-year-old.

7 Q. How did that impact the functional
8 outcome that you would expect following a successful
9 hemiarthroplasty?

10 A. Number one, being as osteoporotic, that
11 probably contributed to the severity of the injury or
12 the fact that the injury occurred at all. Number
13 two, with weak, thin bones, repairs don't always hold
14 up. Also, given her age, she probably had some
15 pre-existing rotator cuff disease, even though she
16 may have been asymptomatic. But the vast majority of
17 patients, once they get in their 60s, have
18 degenerative changes in their rotator cuff that you
19 wouldn't find if they were in their 20s or 30s.

20 Q. Any evidence of prior shoulder injury or
21 rotator cuff injury that you're aware of from your
22 review in this case?

23 A. No. Again, I'm talking about part of the
24 normal aging process.

25 Q. I'm talking about anything more than what

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1 you would expect from the normal aging process.

2 A. No evidence of that, although the normal
3 aging process could be highly variable.

4 Q. But, again, with Nancy Dunham's case, is
5 there something that you say that she had increased
6 likelihood of having less than optimal functional
7 outcome because of her underlying medical condition,
8 other than what you said about the osteoporosis?

9 A. No.

10 Q. And certainly if secondary surgery was an
11 option because of hypothetically discovering a
12 significant portion of the greater tuberosity
13 avulsing, is there anything about her medical
14 condition that would prevent one from pursuing
15 secondary surgery on her?

16 A. I don't see in the records any
17 contraindications to her having surgery.

18 Q. Okay. Now, according to the records, can
19 we agree that the first time that surgery was
20 recommended by Dr. Ghanma was not until February of
21 1996?

22 A. No.

23 Q. You believe Dr. Ghanma recommended
24 surgery to her at some time before February of '96?

25 A. Let me stand corrected. The first time

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1 that he recommended surgery to her was February of
2 '96.

3 MR. TRAVIS: In the records.

4 THE WITNESS: In the records.

5 BY MR. MISHKIND:

6 Q. And he recommended -- what type of
7 surgery did he recommend at that time?

8 A. A shoulder fusion.

9 Q. That would be an arthrodesis, correct?

10 A. Yes.

11 Q. One year out or a year plus two or three
12 months out following this surgery, what would you
13 have recommended?

14 A. In her case, based on my review of the
15 records, not having seen her, I think that's a
16 reasonable option if she was having significant
17 disabling pain.

18 Q. Arthrodesis would only serve to reduce
19 the pain. It certainly would not increase the range
20 of motion, would it?

21 A. It can improve the range of motion in
22 terms of elevation, but will limit motion in terms of
23 rotation.

24 Q. Dr. Brems in his letter to Dr. Ghanma
25 notes in the x-rays that he reviewed that he saw that

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1 the greater tuberosity was displaced and was well
2 above the humeral head. You've had a chance to look
3 at those films, correct?

4 A. Yes.

5 Q. Do you agree or disagree with Dr. Brems?

6 A. I don't agree with that statement if he's
7 basing that on the films that he took or that he
8 reviewed on December 11, 1998 -- I'm sorry, 1996.
9 When I review them, I cannot see that piece on those
10 x-rays. But certainly other films earlier do show a
11 piece up there, as we discussed before.

12 Q. And which films earlier show the greater
13 tuberosity? Those are the ones back in January
14 and -- in January of 1995, correct?

15 A. Yes.

16 Q. And would you agree with his statement
17 that with displacement of the tuberosity for a long
18 time, that marked scarring and complete dysfunction
19 of her superior -- there's a word missing here --
20 superior and probably posterior rotator cuff
21 occurred?

22 A. I would agree with that.

23 Q. Dr. Brems further says in his report that
24 I would be a bit reluctant to recommend a shoulder
25 arthrodesis as it would not only be difficult

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1 technically in the absence of a humeral head, but my
2 experience has been that it transfers pain from the
3 arm into the shoulder blade, particularly in thin
4 females such as this. Would you disagree with that
5 statement?

6 A. I would disagree with that.

7 Q. Why is that?

8 A. That's not been my experience in terms of
9 transferring pain to the shoulder blade in thin
10 females. I think that the indication for doing
11 arthrodesis would be severe disabling pain, and an
12 arthrodesis is very good in terms of relieving that
13 pain. They may not get 100 percent pain relief, but
14 by and large, they are better off afterwards than
15 they were before.

16 Q. If in fact the x-rays in January --
17 January 3rd, January 10th -- show a significant
18 portion of the greater tuberosity having avulsed and
19 the patient is in significant discomfort, would you
20 agree that while not guaranteeing a more successful
21 result, certainly it would have been an acceptable
22 method to go back in and do a secondary surgery to
23 treat the failed surgery of the shoulder?

24 MR. TRAVIS: Objection --

25 THE WITNESS: Are you talking about this

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1 case?

2 BY MR. MISHKIND:

3 Q. Yes.

4 A. I would disagree. I don't find any
5 indication for any surgical intervention in January
6 of 1995.

7 Q. Why?

8 A. Clinically, she was improving her motion,
9 having less pain, and she was doing as expected.
10 There was no indication at that time to perform any
11 surgery. Again, you have to correlate clinical
12 findings with the x-ray. We treat patients. We
13 don't treat x-rays. And based on the clinical
14 records, she -- and plus the x-rays, she did not have
15 a complete avulsion of her rotator cuff. Again, the
16 humeral head was not high rising against the face of
17 the glenoid, and there's documentation from a number
18 of sources that she was continuing to make the
19 expected clinical improvements.

20 Q. What are those sources, Doctor?

21 A. Dr. Ghanma's notes, the physical therapy,
22 and one visit she had to Dr. Viswanath.

23 Q. When was that visit?

24 A. January '95, I think about the middle of
25 the month.

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1 Q. And who is he, what type of doctor?

2 A. I get the impression that it's her family
3 doctor, general medical doctor. She went to see him
4 complaining of hives. It was January 13th, '95.

5 Q. And what significance do you put on that
6 note?

7 A. He makes the comment in the note here:
8 She's doing pretty good on that, except that she has
9 been complaining of recurrence of her hives.

10 The preceding sentence says: She had a
11 broken shoulder and arm and has been operated on by
12 Dr. Ghanma. She's doing pretty good on that, except
13 that she has been complaining of recurrence of her
14 hives.

15 Q. And you give credence to that statement
16 by the doctor that she's doing pretty good with that
17 when he's not the one that operated on her and she
18 goes to see him for hives?

19 A. I would assume that he's putting down
20 there what the patient told him in terms of how she
21 was doing. We also have the records of the physical
22 therapist in terms of how she's doing, and we have
23 Dr. Ghanma's notes.

24 (The proceedings were interrupted.)

25 (Off-the-record conference.)

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1 BY MR. MISHKIND:

2 Q. You read Dr. Kay's deposition, correct?

3 A. Yes.

4 Q. And you saw when Mr. Travis asked him to
5 interpret the January 10, '95, film, his indication
6 was that the film showed fragments of bone superior
7 to the humeral head below the acromion representing a
8 large portion of the greater tuberosity. The greater
9 tuberosity is not in its initial attachment site
10 where it should be.

11 Do you recall essentially that testimony
12 by Dr. Kay?

13 A. Yes.

14 Q. Do you agree or disagree with his
15 interpretation?

16 A. I agree with the fact that there's a
17 piece of bone up there. I disagree with the fact
18 that it is necessarily the major portion of the
19 rotator cuff attachment.

20 Q. And can we agree that if in fact it is
21 the major portion of the greater tuberosity, that
22 coupled with what you state in terms of the clinical
23 facts would be an important element in terms of
24 whether or not to recommend secondary surgery or to
25 treat this patient conservatively?

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1 A. I'm not sure I understand the question.

2 Q. Doesn't it really boil down to Dr. Kay
3 says in looking at the films of January 3rd and
4 January 10th that what he sees represents a large
5 portion of the greater tuberosity; what you see, you
6 feel, does not represent a large portion of the
7 greater tuberosity, that's number one. Can we agree
8 with that?

9 A. Yes.

10 Q. Can we further agree that if what is seen
11 in January does represent a large portion of the
12 greater tuberosity, that has clinical significance in
13 terms of whether or not you need to start thinking
14 about secondary surgery at that point? Can we agree
15 with that as well?

16 A. No, I wouldn't agree with that, because
17 you have to determine if there is clinical
18 significance of that x-ray finding. So you have to
19 again go back to the patient, are there signs and
20 symptoms that correlate with that, because the two
21 have to correlate. In this particular case, they
22 don't correlate. Clinically, she didn't have any
23 evidence of having disrupted her rotator cuff at that
24 time or a major portion of the greater tuberosity
25 that contain the rotator cuff. So the two don't

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1 correlate, and I don't see any indication at that
2 time that there was to even consider surgery or to
3 discuss surgery.

4 Q. Would you agree that if the greater
5 tuberosity is detected to have shifted during the
6 first two or three weeks, it would be a good idea to
7 go back in and operate if you feel you can get
8 adequate fixation for the patient?

9 A. If the patient has clinical evidence that
10 it has shifted and detached, then, yes, you'd want to
11 go reattach. But that's not the case here.

12 MR. TRAVIS: Would you read that question
13 and answer back?

14 (The Court Reporter read the question
15 commencing on page 78, line 15, and the answer
16 concluding on page 78, line 11.)

17 BY MR. MISHKIND:

18 Q. On January 3, the first of those two
19 films that we've been spending a lot of time talking
20 about, is there any evidence of migration of the
21 tuberosity?

22 A. There is a piece of bone in the
23 subacromial space above the humeral head that does
24 not appear to be there on the previous film of
25 December 18, '94, talking about the film of January

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1 3rd of '95, and it appears to be unchanged on the
2 film of January 10, '95.

3 Q. But going back to my question, on January
4 3, does there appear to be any evidence of migration
5 of the tuberosity from what was evident before
6 January 3?

7 A. Taking the clinical picture and the x-ray
8 into account, there does not appear to be migration
9 of the rotator cuff or the tuberosity piece of bone
10 that it's attached to.

11 Q. Does there appear to be any migration of
12 the tuberosity from a radiological standpoint?

13 A. Again, there's a piece of bone in the
14 subacromial space above the humeral head on the film
15 of January 3rd, '95, that was not there on the film
16 of December 18, '94. On those films of January of
17 '95, though, you do see other pieces of tuberosity
18 still attached where they were put back.

19 Q. Do you have any explanation for why on
20 January 3 you see that portion of the tuberosity,
21 whereas you didn't see it on the previous film?

22 A. Again, as Ghanma mentions, there were a
23 lot of small, loose, broken pieces, and it could have
24 migrated, moved, because the patient is moving, so
25 things get pushed around and moved around.

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1 Q. Could you state that based upon her
2 pre-operative osteoporosis that Mrs. Dunham was
3 likely down the road to develop problems where her
4 greater tuberosity would not heal? Do you follow my
5 question?

6 A. Not really.

7 Q. Okay. Not knowing what happened, but
8 knowing what the patient's pre-operative and
9 intraoperative condition was, could you state to a
10 reasonable degree of probability that down the road
11 it was likely that her greater tuberosity would
12 probably not heal or that she had a likelihood of not
13 healing?

14 A. You're talking about developing a
15 malunion as opposed to the tuberosity pulling off?

16 Q. Tuberosity pulling off, malunion, or
17 nonunion. Just to put it in proper context, could
18 one say -- without having a crystal ball, could one
19 say at the time of the operation that because of this
20 patient's osteoporosis, it's more likely than not
21 down the road she was likely to have the greater
22 tuberosity avulse or the greater tuberosity have a
23 malunion or a nonunion, or would that just not be
24 something that one could state to a reasonable degree
25 of probability?

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1 A. I think to a reasonable degree of
2 probability or medical certainty, patients with
3 osteoporosis are going to have more problems in terms
4 of getting things to heal or heal in a satisfactory
5 position than those people that do not have
6 osteoporosis.

7 Q. And I appreciate that, but can you state
8 to a probability before doing this hemiarthroplasty
9 that it was likely that she was not going to heal
10 because of her osteoporosis?

11 A. In her specific case?

12 Q. Yes.

13 A. I don't think you can say that at all.

14 Q. Okay. She had some type of
15 hypothyroidism, correct?

16 A. Yes.

17 Q. Was that in any way a factor that made
18 her a poor surgical risk, in your opinion?

19 A. No.

20 Q. When is the last time that you know of
21 that Dr. Ghanma performed any x-rays to assess the
22 status of her -- the anatomical position of her
23 shoulder?

24 A. The last set of x-rays she got in the
25 immediate post-operative period was March 7th, '95.

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1 Q. And then he continued to see her through
2 August of 1995, correct?

3 A. Correct.

4 Q. So between March and August, there are no
5 further x-rays to look at to see what the status is
6 of the greater tuberosity and the surrounding
7 structures, correct?

8 A. Correct.

9 Q. Do you have any explanation for why no
10 further x-rays were taken during that period of time?

11 A. I don't see any clinical indication for
12 it. I think that by the March visit, she had healed.
13 And unless there's a specific clinical indication, I
14 don't think you're obliged to have to get x-rays at
15 every visit. There's no indication for it.

16 Q. If the greater -- a significant portion
17 of the greater tuberosity had avulsed in January of
18 1995 and if her clinical status was such that a
19 reasonable and prudent orthopedic surgeon would have
20 considered going back in and doing secondary surgery,
21 would she have been, from a medical standpoint, an
22 appropriate candidate for surgery?

23 A. Again, as you asked before, I don't see
24 any contraindication to surgery at any time either in
25 December, January, February, March, or down the road.

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1 Q. And can we agree again with the
2 hypothetical that we are dealing with the greater
3 tuberosity avulsing -- and it's not just a small
4 portion, but a substantial portion of the greater
5 tuberosity -- and her clinical symptoms were such
6 that a reasonable and prudent orthopedic surgeon
7 would have entertained secondary surgery, would you
8 agree with me that Mrs. Dunham would have had a
9 better chance to achieve a shoulder with less pain
10 and a shoulder with greater range of motion than if
11 she were treated nonsurgically?

12 MR. TRAVIS: Objection.

13 THE WITNESS: There are a lot of
14 hypotheticals in there that don't apply to this case,
15 so you lost me.

16 BY MR. MISHKIND:

17 Q. Again, they may or may not apply. These
18 are fact questions. I understand your
19 interpretation, what you see in the films. We agree,
20 can we not, that you and Dr. Kay do not see eye to
21 eye in connection with this case in terms of the
22 interpretation of the films and what should have been
23 done?

24 A. It's not just the films. It's the films
25 and taking the patient's clinical status into

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1 account. We obviously have a difference of opinion.
2 He seems to want to just read the x-rays, and I think
3 it's important to look at the x-rays and the patient.
4 As I said, we treat patients. We don't treat x-rays.

5 Q. You may or may not be correct with that,
6 but can we agree that you and Dr. Kay in reviewing
7 this case intellectually come to different opinions?

8 A. Obviously.

9 Q. And your conclusion is that surgery was
10 not warranted in January of 1995, and his was that it
11 was warranted?

12 A. Correct.

13 Q. And what I'm saying to you is,
14 hypothetically, if the circumstances were such that
15 you were saying that this is a substantial portion of
16 the greater tuberosity, it has avulsed, and that
17 clinically the patient was an appropriate candidate
18 to have at least had consideration for secondary
19 surgery, under that hypothetical -- I know you
20 disagree with the facts -- but under that
21 hypothetical, would you agree Mrs. Dunham would have
22 had a greater chance to have achieved a shoulder with
23 less pain and a shoulder with greater range of motion
24 by having the surgery as opposed to being treated
25 conservatively?

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1 MR. TRAVIS: Objection to the
2 hypothetical which says nothing about her clinical
3 pain situation. You can answer.

4 THE WITNESS: Again, I'm not sure you can
5 answer that, because in her case here, at the time
6 we're talking about, she was having less pain,
7 improving her motion, and clinically doing well. So
8 I find it hard to imagine how you could improve upon
9 that when she's doing well and fully following her
10 expected clinical course. Any time you reoperate,
11 whatever factors were responsible for things failing
12 the first time are still there. So you still have a
13 chance at things failing, not doing well. Whatever
14 happened the first time can happen the second time.
15 Anytime you go back early on, anytime you go back
16 anytime, but particularly early on, you have
17 increased risk of complications.

18 BY MR. MISHKIND:

19 Q. I understand that there are risks and
20 complications. But can we agree that weighing and
21 balancing the risks and complications, if a decision
22 is made that secondary surgery is warranted, that the
23 chance of the patient achieving a shoulder on a
24 permanent basis that would have less pain and have
25 greater range of motion would be increased by going

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1 back in and doing a secondary repair as opposed to
2 treating the patient nonsurgically?

3 MR. TRAVIS: Objection to the
4 hypothetical. You can answer if you can, Doctor.

5 THE WITNESS: If you're talking about a
6 purely hypothetical situation where it looks like the
7 major portion pulled off and clinically they cannot
8 elevate their arm at all and they have pain, so
9 you're convinced the cuff is not attached, then, yes,
10 you do have a better chance of it attaching and
11 staying attached if you go back and operate and put
12 it there. Because if it truly has detached and it is
13 a significant distance away from where it's supposed
14 to be so it's not going to heal, then it's never
15 going to heal there on its own, and the only way to
16 get it back there to give it a chance to heal would
17 be with an operation. But, once again, whatever
18 circumstances and causes were present initially for
19 that to happen are still there the second time.

20 BY MR. MISHKIND:

21 Q. But weighing and balancing going in and
22 doing surgery versus doing nothing, the patient would
23 have a better likelihood of a good outcome by going
24 in and doing surgery as opposed to doing nothing for
25 the patient, given that hypothetical?

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1 A. In the hypothetical I just outlined, they
2 would have a better chance. Doesn't mean they would
3 have a better result, but they would have a better
4 chance.

5 Q. Doctor, you state in reading
6 Mrs. Dunham's or the Dunhams' depositions: Little
7 help, patient recollection often inaccurate.

8 What is it that you mean when you state
9 that the deposition is of little help?

10 MR. TRAVIS: Objection to your
11 interpretation of what he meant by that. You can
12 answer. And if you can you show him --

13 BY MR. MISHKIND:

14 Q. It says: Dunham deposition little help,
15 patient recollection often inaccurate.

16 That's all you marked down in the Dunham
17 deposition. I'd like to know what it is about the
18 Dunham deposition that warranted a two-line statement
19 and is of little help to you in terms of coming to
20 the truth in this case.

21 A. It didn't provide me with any significant
22 fact information to change my opinion.

23 Q. Were questions asked sufficient enough so
24 you could understand what the subjective symptoms and
25 the progress of the patient was between December when

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1 the surgery was done and the end of August of '95
2 when she was initially told to come back in three to
3 four months or essentially discharged from active
4 treatment?

5 A. I felt the questions were adequate, yes.

6 Q. Tell me what you learned from your review
7 of the deposition as to what Mrs. Dunham said about
8 the level of pain that she was having and the
9 functionality of her shoulder during that period.

10 A. Based on her deposition, she was having
11 increased amounts of pain and decreased function that
12 contradicts what's in the medical records.

13 Q. And you would agree that Dr. Ghanma
14 claims that he discussed the option of surgery with
15 Mrs. Dunham, even though it wasn't something that he
16 was recommending, that he discussed that with her
17 sometime in January of 1995, correct?

18 A. I think that he mentioned -- my
19 interpretation is that he mentioned the finding on
20 the x-ray, and that that could potentially become
21 something in the future that they might have to
22 reoperate on.

23 Q. Do you recall from reading Dr. Ghanma's
24 deposition that he did in fact discuss with
25 Mrs. Dunham in January of 1995 the option of surgery,

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1 but he did not feel, nor did he recommend to her at
2 that time, that surgery was an appropriate option?

3 A. Yes, I believe he mentioned that to her.

4 Q. Yet there's nothing in his office records
5 that is consistent with that testimony, is there?

6 A. That's correct.

7 Q. You've chosen to believe Dr. Ghanma over
8 Mrs. Dunham; is that correct?

9 MR. TRAVIS: Objection. You can answer.

10 THE WITNESS: I didn't say that.

11 BY MR. MISHKIND:

12 Q. Dr. Ghanma's testimony is inconsistent
13 with what he has in his records?

14 A. It's not inconsistent. It's just not
15 well-documented in his records. There's nothing
16 that's inconsistent about it or contradicts it.

17 Q. Is there anything that you believe
18 Mrs. Dunham did that caused or contributed to the
19 failed hemiarthroplasty?

20 A. No, nothing specifically, no.

21 Q. If a shoulder hemiarthroplasty is
22 performed and the results are successful or what you
23 consider to be within successful ranges for the
24 treatment of a fracture, three- or four-part
25 fracture, what do you consider to be acceptable range

1 of motion following such a surgery?

2 A. Oh, I think that varies from patient to
3 patient. I think it depends on their age,
4 occupation, their goals, their expectations.

5 Q. Let's deal with Mrs. Dunham. Given her
6 age, her medical history, the type of fracture she
7 suffered, based upon your experience and the studies,
8 whether they're Neer studies or anyone else's that
9 you follow, what do you believe to be an acceptable
10 range of motion following successful
11 hemiarthroplasty?

12 A. If they can get their arm up to at least
13 shoulder level or above and if they can turn their
14 arm out, or what we call externally rotate, about 30
15 degrees, I think that will allow them to carry out
16 most activities of daily living.

17 Q. So you're talking about up to shoulder
18 level, that's 90 degrees?

19 A. Yes.

20 Q. And there are studies -- Neer, I think
21 goes as high as 115 or 120 degrees of active
22 elevation?

23 A. You mean in terms of his results?

24 Q. Right, or as to what he considers to be
25 acceptable range of motion following successful

1 hemiarthroplasty.

2 A. I'd have to go back and check and see if
3 that's what Neer considers to be acceptable.

4 Q. Would you agree, though, that anywhere
5 between 90 and somewhere in the low 100s is an
6 acceptable range of motion, depending on whose study
7 you look at?

8 A. I think that's what we'd like to aim for,
9 and if you achieve that, the patient will be able to
10 carry out most daily activities and would have what
11 we would call a satisfactory result.

12 Q. And you're not able to cite me to any
13 studies that would permit you to say, if secondary
14 repair is necessary within a short period of time
15 after the failed primary repair, how much lower that
16 active range of motion would be, are you?

17 A. Correct.

18 Q. What is your understanding as to her
19 active range of motion now, based upon your review of
20 the records?

21 A. The last office note by Ghanma in
22 February of '96 said that she had elevation or what
23 he called forward flexion of 35 to 40 degrees, and
24 the evaluations by Dr. Brems in December of '96 would
25 agree with that -- I'm sorry, January of '97, would

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1 agree with that.

2 Q. Would you have any reason to believe that
3 her range of motion would likely be significantly
4 different today, based upon what you have in these
5 two landmarks?

6 A. No, I would expect it to be very similar.

7 Q. And with that degree of range of motion,
8 does that impact one's ability to do activities of
9 daily living?

10 A. Yes.

11 Q. And what kind of activities of daily
12 living are restricted as a consequence of that
13 limitation?

14 A. Well, she'll have trouble doing anything
15 at shoulder height since she cannot actively get her
16 arm up there. My understanding is she can passively
17 put it up there, and if she does that, then she can
18 carry out some things. Patients learn to adapt in
19 various ways to various limitations, So without
20 evaluating her specifically, it would be hard to say
21 specifically what daily activities she's not able to
22 do, because, again, sometimes they may miss the
23 active part, but can do it passively. So one hand
24 helps the other up, and they manage.

25 Q. We can certainly agree that 40 degrees of

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1 range of motion is not considered a good outcome
2 following a hemiarthroplasty, correct?

3 A. In terms of motion, that's correct.

4 Q. And certainly the patient continues to
5 experience, at least from what you have reviewed,
6 pain on a daily basis, correct?

7 A. She has pain, but it's hard to -- you
8 know, pain is such a subjective thing. It's hard to
9 quantitate. The only guide I have here is in
10 Dr. Brems' note when he says, because the patient is
11 taking so little Darvocet, to me, that means she's
12 not having that much significant pain that she's
13 requiring heavy-duty narcotics all the time for the
14 shoulder. But, again, it's a very subjective thing,
15 and I don't see any objective evaluation of her pain
16 anywhere in the notes.

17 Q. When you talk about the clinical status
18 of the patient, part of that clinical status of the
19 patient involves subjective statements by the patient
20 as well as objective findings, correct?

21 A. Yes.

22 Q. And when you read over Mrs. Dunham's
23 deposition, what did you learn relative to the degree
24 of pain that she's experiencing as of 1998 or 1999?

25 A. To her, she's experiencing a great deal

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1 of pain or a fair amount of pain. And that seems to
2 be in conflict with some of the records that I've
3 reviewed.

4 Q. Are you suggesting that Mrs. Dunham is
5 being less than candid in her statements of her pain?

6 A. No.

7 Q. Why do you mention that they are in
8 conflict?

9 A. A couple of things. I think early on,
10 you've got the records of Dr. Ghanma, you've got the
11 physical therapist, and you've got that one mentioned
12 note by her GP about how she's doing, and you get a
13 certain impression which is at odds with how she
14 describes the way she was. And then subsequent to
15 that, she's taking a lot of Darvocet, but some of
16 that appears to be for her back and not for her
17 shoulder. But she has the impressions for her
18 shoulder and not her back. But there is
19 documentation she's been given Darvocet for her back,
20 and she has a long history of back problems.

21 Q. Doctor, can we agree that there's nothing
22 in the records that Dr. Ghanma ever discussed with
23 Mrs. Dunham the option of going back in and doing
24 further surgery at any time in 1995?

25 A. In his records, that's correct.

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1 Q. And are you able -- looking at the office
2 records of Dr. Ghanma or the physical therapy
3 records, are you able to identify a month where you
4 believe more likely than not she developed evidence
5 of a failed hemiarthroplasty?

6 A. What do you mean by failed
7 hemiarthroplasty?

8 Q. Disruption of or avulsion of the greater
9 tuberosity.

10 A. Again, as I've said, I think that her
11 rotator cuff at some point down the road became
12 dysfunctional and may or may not have torn. I think
13 it was probably a slow process over time as opposed
14 to a sudden event, but it's hard to say with any
15 certainty when that occurred.

16 Q. Okay. Dr. Kay has testified that when
17 she avulsed her greater tuberosity in January of
18 1995, that is when she had the rotator cuff tear. Do
19 you disagree with Dr. Kay?

20 A. Yes.

21 Q. Dr. Kay is also of the opinion that while
22 there is no guarantee that she would have had a
23 successful outcome from a secondary surgery, he feels
24 to a probability she would have had a dramatically
25 better shoulder had she undergone a repeat operation.

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1 Do you agree or disagree with him?

2 A. I disagree with that.

3 Q. And the reason being?

4 A. There is no basis of foundation. I think
5 he gave numbers of 80 percent improvement in pain
6 relief and 50 percent improvement in function. There
7 is just no basis that I know of for that, and it's
8 not been my clinical experience.

9 Q. If she had had a secondary surgery to
10 treat an avulsion of the greater tuberosity and a
11 rotator cuff disruption, would you agree that she
12 would have had a 50/50 chance of receiving a good
13 outcome?

14 A. Again, it depends how you define good
15 outcome. But if in fact she had disruption of her
16 rotator cuff at that time, which obviously I don't
17 think she had, to go back and operate on her would
18 have given her a better chance at having improved
19 outcome compared to not doing it, as we've talked
20 about.

21 Q. Do you have any criticism of what was
22 done by the physical therapist in the treatment of
23 Nancy Dunham?

24 A. No.

25 Q. What I'd like you to do, Doctor, so that

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1 I don't have to strain my eyes in reading this, is
2 I'm going to have you read the back of plaintiff's
3 exhibit 2, which is the notes on Dr. Ghanma's depo.
4 Read them slowly into the record for the benefit of
5 me and, more importantly, the court reporter. And
6 then after that, I'm going to have you read your
7 notes on Dr. Kay's deposition. Okay?

8 A. Sure. This will be with reference to
9 Dr. Ghanma's deposition.

10 Page 63, double shadow is not equal to
11 loosening, is a radiosclerotic line of no significant
12 consequence. Rotator cuff can fail, even if repair
13 held up, because tissue is damaged in fracture and
14 bone osteoporotic and patient old and cuff already
15 worn because of age. Therefore, reoperating will not
16 help the situation.

17 I have a note off to the side: Check
18 immediate post-op x-ray versus film of 1-3 and
19 1-10-95.

20 Q. Let me interrupt you for one second and
21 ask you a question about that. You said reoperation
22 would not help the situation. You're not saying in
23 100 percent of the cases, because of what you believe
24 to be an old patient with the injury and her
25 osteoporosis, that reoperation would be doomed to

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1 failure, are you?

2 A. No, it's just if they didn't have a
3 rotator cuff.

4 Q. Okay.

5 A. Again, these are notes that I jot down as
6 I'm going along. I wouldn't take it as fact. I may
7 put something down that I find was wrong later or may
8 state something that I change my mind about later.
9 So, again, I wouldn't --

10 Q. No, I'm just asking you --

11 A. -- wouldn't put a lot of weight to this.

12 Q. I'm just asking you questions as we go
13 through this so I won't have to wait until the end.

14 A. Okay. And, again, I may put something
15 down that I changed my mind about as I read more and
16 find out more. So if it's at odds with what's in the
17 letter, I think what's in the letter is what ought to
18 be taken as my opinions.

19 Q. Well, in all fairness, what you say in
20 totality are your opinions, whether they're in the
21 letter or whether they're subject to
22 cross-examination. So that's why I'm asking you.

23 A. But, again, if I write something down
24 here as I'm going through it and I've got questions
25 or misunderstand something that becomes more clear

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1 later, I may have a complete different opinion by the
2 time I'm done.

3 Q. Are you suggesting on the record that
4 you've changed your opinions as you've got through
5 this case?

6 A. No, I think my opinions are stated in the
7 letter of --

8 Q. March 17?

9 A. -- March 17, 1999.

10 Q. In that letter you indicated that you
11 reviewed the medical records and x-rays sent,
12 correct?

13 A. Correct.

14 Q. You didn't mention anything about the
15 depositions, having reviewed them. I take it you
16 didn't review them for purposes of your letter?

17 A. I have reviewed the depositions. They
18 come under records.

19 Q. So medical records should really be -- to
20 make this accurate, medical records should be medical
21 records and depositions?

22 A. If you'd like. I consider them all part
23 of the same thing.

24 Q. You consider the deposition testimony to
25 be medical records?

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1 A. Part of the records that were sent to me.

2 Q. Okay. Go ahead, Doctor.

3 A. Page 70, injury may not necessarily be
4 anything she remembers or had immediate reaction to.
5 Patients can tear rotator cuff months after surgery.
6 May not be aware of it and can lead to poor result.
7 Surgery often not successful because cuff gone or
8 irreparable. Page 82, if reoperate, do for pain, not
9 function. Patient wasn't having severe pain to
10 warrant reoperation. Page 84, can get proximal
11 migration without tear, can be due to dysfunction.
12 Page 87, by March, three months post-op, all healed,
13 and, therefore, don't necessarily need any more
14 x-rays unless specific clinical indication.

15 Q. Let me stop you for one second and ask
16 you a question. You're not of the opinion that at
17 the time of the surgery, the hemiarthroplasty, that
18 her rotator cuff was gone, are you?

19 A. No.

20 Q. You acknowledge that at some time after
21 the surgery, there is a disruption or a tear to the
22 rotator cuff?

23 A. Or dysfunction, yes.

24 Q. Which may be a combination of some
25 underlying conditions as well as a disruption that

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1 ensued following the surgery?

2 A. As well as injury from the time of the
3 fracture, yes.

4 Q. But as to when that occurred, you're not
5 able to give me to a reasonable degree of probability
6 a time period that you'll be able to testify to at
7 trial, correct?

8 A. Not with any certainty, that's correct.

9 Q. Okay. Go ahead, Doctor.

10 A. Page 98, surgery not successful, but not
11 due to negligence, malpractice, or deviation.

12 Q. So there's no question that this was a
13 failed surgery on the part of the doctor. It's just
14 that you're going to take the stand and say that this
15 failed surgery was not due to any negligence on his
16 part?

17 A. Correct.

18 Q. Does that conclude your comments on
19 Dr. Ghanma's deposition?

20 A. Yes.

21 Q. And we've already talked about the two
22 lines in terms of what you said about Mrs. Dunham's
23 or the Dunhams' depositions, correct?

24 A. Yes.

25 Q. Next you have Dr. Kay's comments?

1 A. Comments on Dr. Kay's deposition, yes.
2 Page 26, difference between three- and four-part
3 fractures can be significant regarding treatment and
4 outcome. Page 27, AVN do better because --

5 Q. Wait, what was that?

6 A. AVN, avascular necrosis --

7 Q. Okay.

8 A. -- do better because the cuff is normal,
9 tuberosities are not fractured off. Status of
10 tuberosities and cuff most significant factors
11 affecting outcome. Page 29, younger patients do
12 better because better bone quality and better cuff
13 tissue. 31, x-rays could be normal, but patient has
14 osteoporosis. Therefore, need other tests. See
15 osteoporosis on plain x-rays. Therefore, don't need
16 other tests.

17 Q. There weren't any other tests that had
18 been done to demonstrate osteoporosis at any time
19 prior -- in her shoulder area prior to her surgery,
20 are there?

21 A. She had a number of x-rays done that
22 demonstrated osteoporosis. I don't believe she had a
23 bone densitometry.

24 Q. Nothing in the shoulder, correct?

25 A. Correct. The shoulder is not a typical

1 place you measure for osteoporosis, by the way. Page
2 39, reoperating with poor cuff tissue would not make
3 her better. The point is that results vary greatly
4 in clinical judgment, not simple as tuberosity is
5 pulled off and just reattach them. Usually other
6 problems and more complicated. And same reasons for
7 failure first time, i.e., poor bone, poor cuff still
8 exist.

9 Q. Doctor, as you're going through these,
10 these are areas you're essentially taking issue with
11 what Dr. Kay said in his deposition, correct?

12 A. Yes, or just commenting on them.

13 Q. But mostly it seems like these comments
14 are areas where you disagree with what Dr. Kay has
15 said, correct?

16 A. Yes. Page 40, tuberosities don't pull
17 off, but cuff tissue attenuates and tears. Page 69,
18 dramatizing, not relevant and excessive.

19 Q. What does that mean?

20 A. I'd have to go back and look what he was
21 talking about.

22 Q. At page 69?

23 A. Yes.

24 Q. Okay.

25 A. Operating not without risks, not

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1 necessarily -- something -- not necessarily something
2 to improve her specific situation, and problems can
3 arise, was a judgment call by Ghanma within standard.
4 Page 70, patient's cuff not normal when she fell,
5 aged and worn. Page 70, shredded is possible with
6 this injury.

7 Q. I'm sorry, what was that?

8 A. Shredded, quotation marks, is possible
9 with this injury. Cuff can get beaten up and is
10 already non-normal. Page 78, we know what she ended
11 up with. Ghanma didn't know result at time. He made
12 a reasonable clinical judgment. Page 84, patient
13 wasn't having significant pain at the time in
14 question, therefore, what was he going to offer her.
15 Functional increase much less than 50 percent. M.D.
16 made a reasonable judgment call at the time. Just
17 because it did not turn out correct, what that does,
18 it does not equal negligence or deviation.

19 Q. You said functional increase much less
20 than 50 percent?

21 A. Yes, referring to his comment that she
22 could expect 50 percent functional improvement.

23 Q. And your opinion is that with secondary
24 surgery, had that been something that a reasonable
25 and prudent orthopedic surgery would have done, it's

1 likely that her functional improvement would have
2 been less than 50 percent?

3 A. I think what I was saying there is at the
4 time that we're talking about, she was making the
5 expected improvements in pain and function and
6 following an expected post-operative course, that I
7 don't see what she was going to improve upon that she
8 otherwise looked like she was getting from her
9 continued post-operative treatment.

10 Q. Anything else in Dr. Kay's deposition
11 that you felt significant enough in terms of taking
12 issue with that you marked it down?

13 A. Nothing else that I wrote down.

14 Q. And is there anything else that you can
15 think of, based upon your recent review of the
16 deposition that you take issue with?

17 A. Not that we haven't already discussed.

18 Q. Anything that you otherwise take issue
19 with in Dr. Kay's opinions other than what we have
20 already discussed?

21 A. No.

22 Q. Have we covered all of the opinions that
23 you hold in this case?

24 A. Yes.

25 Q. Do you intend to review any further

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1 information or records or do any further research
2 prior to flying up to the best location in the nation
3 for purposes of this trial?

4 A. If Mr. Travis sends me something, I will
5 surely review it. I don't plan on doing any
6 independent reviews or research on my own.

7 Q. Give me just a second, Doctor, we may be
8 done.

9 What's your understanding, Doctor, as to
10 why Mrs. Dunham did not have an arthrodesis performed
11 by Dr. Ghanma when she returned in February of 1996?
12 You're looking to Dr. Ghanma's office records to
13 answer this question?

14 A. I am looking at that. She obviously
15 decided she didn't want to have it done.

16 Q. And do you recall the explanation given
17 by the patient as to the reason she didn't have --

18 A. No.

19 Q. But in responding to that question, you
20 first went to Dr. Ghanma's records and didn't go to
21 her testimony, correct?

22 A. Correct.

23 Q. Do you find it unreasonable, on the
24 patient's part, given the history that she had gone
25 through, to decline having an arthrodesis in February

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1 of 1996?

2 A. No.

3 Q. Do you still use the Constant Scoring
4 System in assessing results following a
5 hemiarthroplasty?

6 A. Sometimes I use the Constant Scoring,
7 sometimes we use the American Shoulder & Elbow
8 Surgeons. But we don't always do that every visit,
9 every patient.

10 Q. And have you found that the results
11 following total shoulder arthroplasty are still
12 fairly consistent with the results of your article
13 back in July of 1998 that you did with Dr. Hartsock?

14 A. That article didn't have anything to do
15 with total shoulder arthroplasty.

16 Q. Shoulder hemiarthroplasty?

17 A. For fractures.

18 Q. For proximal humeral fractures, right.
19 And you find that the results following proximal
20 humeral fractures -- the hemiarthroplasties for
21 proximal humeral fractures, that the results in terms
22 of functional results and the results from pain
23 are -- continue to be fairly consistent in practice
24 and in what the literature shows?

25 MR. TRAVIS: Objection, if you understand

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1 that question.

2 THE WITNESS: Again, that is more of a
3 review article than any review of our specific
4 patients. And I would say in the year since that was
5 written, there has not been anything significantly
6 different from what was known at the time that
7 article was written.

8 MR. MISHKIND: No further questions,
9 Doctor. Thank you.

10 THE WITNESS: Thank you.

11 (The witness, after having been advised
12 of his right to read and sign this transcript, does
13 not waive that right.)

14 (The deposition was concluded at 3:42
15 PM.)

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SIGNATURE OF DEPONENT

I, the undersigned, RICHARD J. FRIEDMAN, M.D., do hereby certify that I have read the foregoing deposition and find it to be a true and accurate transcription of my testimony, with the following corrections, if any:

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RICHARD J. FRIEDMAN, M.D. Date


1 CERTIFICATE OF REPORTER

2
3 I, Janice N. Shepherd, Certified Shorthand
4 Reporter and Notary Public for the State of South
5 Carolina at Large, do hereby certify:

6 That the foregoing deposition was taken before
7 me on the date and at the time and location stated on
8 page 1 of this transcript; that the witness was duly
9 sworn to testify to the truth, the whole truth, and
10 nothing but the truth; that the testimony of the
11 witness and all objections made at the time of the
12 examination were recorded stenographically by me and
13 were thereafter transcribed by computer-aided
14 transcription; that the foregoing deposition as typed
15 is a true, accurate, and complete record of the
16 testimony of the witness and of all objections made
17 at the time of the examination.

18 I further certify that I am neither related to
19 nor counsel for any party to the cause pending or
20 interested in the events thereof.

1 Witness my hand, I have hereunto affixed my
2 official seal this 4th day of August, 1999, at
3 Charleston, Charleston County, South Carolina.
4
5
6

7 
8 Janice N. Shepherd,
9 Certified Shorthand Reporter
 My Commission expires
 October 31, 2004

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February 4, 1999

Richard J. Friedman, M.D.
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FEDERAL EXPRESS

Re: **Nancy Dunham, et al. v. Manhal Ghanma, M.D.**

Case No. 97 CV 119540

Judge McGough

Our File #: 94418-101386

Dear Dr. Friedman:

Thank you for agreeing to review this case on behalf of our client, Dr. Manhal Ghanma with respect to the above-captioned matter.

I am enclosing for your review, a copy of the report from the plaintiff's expert, Dr. Kay. Also please find the following medical records of the plaintiff, Nancy Dunham:

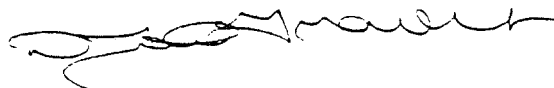
- 1) Dr. Ghanma's Office Chart;
- 2) Elyria Memorial Hospital;
- 3) The Cleveland Clinic Foundation;
- 4) Dr. Viswanath;
- 5) Dr. Carandang; and
- 6) CVS Pharmacy.

Also please find in a separate envelope, a copy of Dr. Ghanma's x-ray films.

Your one hour retainer of \$500 will be forwarded to you from Ohio Insurance Guaranty Association. After you have had the opportunity to review these records, please call me at 1-800-229-5310 with your thoughts.

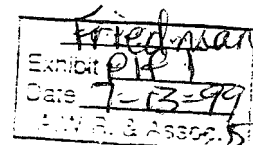
Received 2/18/99

Very truly yours,



D John Travis

DJT:pmd



- 4 pt. - 11/15/94 - procedure indicated - jumping down

- Xray - T5-T6 11/15/94

- post op - 11/15/94 - correct

- Xrays - 11/15/94 - reported us ok - show laminectomy good off

11/15/94 - laminectomy displaced

12/96 - recommended fusion

12/96 - William consulted

1/97 - Brian consulted

Clinical - pt was progressing

↓ pain + 9 days - none or clinical

↓ leg pain is certain I think and no

re-operations - pt was getting better

(after 11/15, 11/29, 1/17, 2/21, 3/17)

- if re-operations, 90% risk of complications

that in quarter rest would be very better

Xrays

3 2

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February 22, 1999

VIA FEDERAL EXPRESS

Richard J. Friedman, M.D.

33 Rebellion Road
Charleston, SC 29407

Re: Case: *Dunham, et al. v. Manhāl Ghanma, M.D.*
Claim #: 105402
Our File #: 94418-101386

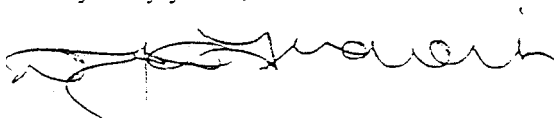
Dear Dr. Friedman:

Enclosed for your review are the following.

- Deposition transcript of Dr. Ghanma.
- 2 Deposition transcript of Nancy Dunham: ana
- 3 Deposition transcript of Charles Dunham.

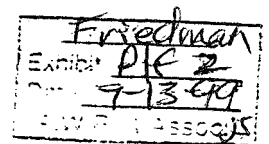
Thank you.

Very truly yours,



D John Travis

DJT:njm
Enclosures



475

$\frac{d}{dt} \left(\frac{\partial L}{\partial \dot{x}} \right) = - \frac{\partial L}{\partial x}$

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1904 10 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1

Ballo - can't fix migration = too low in due to dysfunction.

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System 10: Energy profile of the reaction of 2-ethyl-2-butanol with HCl

(numbering) and to be successful in life has
 to be a very good person

1. 1941

1947-1948

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

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With 4 hours of sleep

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- is a redox reaction in which no species converges

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1911

Dipodomys deserti

Law Offices of
GALLAGHER, SHARP, FULTON & NORMAN

Seventh Floor - Bulkley Building - 1501 Euclid Avenue
Playhouse Square - Cleveland, Ohio 44115
Telephone (216) 241-5310 - Fax (216) 241-1608
Internet: <http://www.gsfn.com>

D John Travis
Direct Dial: 216-522-1590

June 22, 1999

Richard J. Friedman, M.D.
33 Rebellion Road
Charleston, SC 29407

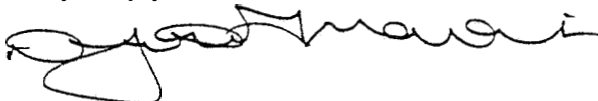
Re: Case: *Dunham, et al. v. Manhal Ghanma, M.D.*
Claim #: 105402
Our File #: 94418-101386

Dear Dr. Friedman:

Enclosed is a transcript of the deposition of Dr Kay

Please review this **and** call me at your earliest convenience.

Very truly yours.



D John Travis

DJT:njm
Enclosure

